



Provider Manual

Provider Services Department: **1-855-772-9076**
[AetnaBetterHealth.com/California](https://www.aetna.com/betterhealth/california)



Aetna Better Health® of California

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CHAPTER 1: INTRODUCTION TO AETNA BETTER HEALTH® OF CALIFORNIA

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Welcome

Welcome to Aetna Better Health of California a Medi-Cal Managed Care Plan. Our ability to provide excellent service to our members is dependent on the quality of our provider network. By joining our network, you are helping us serve those Californians who need us most. For the purpose of this manual, “provider” refers to practitioners (licensed health care professionals who provide health care services) and providers (institutions or organizations that provide services) that have agreed to provide covered services to health plan members pursuant to a participating health provider agreement (“contract”).

Experience and Innovation

Aetna Medicaid has more than 30 years’ experience in managing the care of the most medically vulnerable. We use innovative approaches to achieve both successful health care results and maximum cost outcomes.

We are dedicated to enhancing member and provider satisfaction, using tools such as predictive modeling, care management, and state-of-the art technology to achieve cost savings and help members attain the best possible health, through a variety of service models.

We work closely and cooperatively with physicians and hospitals to achieve durable improvements in service delivery. We are committed to building on the dramatic improvements in preventive care by facing the challenges of health literacy and personal barriers to healthy living.

Today Aetna Medicaid owns and administers Medicaid managed health care plans for more than three million members. In addition, Aetna Medicaid provides care management services to hundreds of thousands of high-cost, high-need Medicaid members. Aetna Medicaid utilizes a variety of delivery systems, including fully capitated health plans, complex care management, and administrative service organizations.

Meeting the Promise of Managed Care

Our state partners choose us because of our expertise in effectively managing integrated health models for Medicaid that provides quality service while saving costs. The members we serve know that everything we do begins with the people who use our services – we care about their status, their quality of life, the environmental conditions in which they live and their behavioral health risks. Aetna Medicaid has developed and implemented programs that integrate prevention, wellness, disease management and care coordination.

We have particular expertise in successfully serving children with special health care needs, children in foster care, persons with developmental and physical disabilities, women with high-risk pregnancies, and people with behavioral health issues.

Aetna Medicaid distinguishes itself by:

- More than 30 years’ experience managing the care and costs of the Temporary Assistance for Needy Families (TANF), Children’s Health Insurance Program (CHIP) and Aged, Blind and Disabled (ABD) (both physical and behavioral) populations
- More than 30 years’ experience managing the care and costs of the developmentally disabled population, including over 9,000 members served today through the Mercy Care Plan in Arizona
- 20 years’ experience managing the care and costs of children and youth in foster care or other alternative living arrangements
- Operation of a number of capitated managed care plans
- Participation on the Center for Health Care Strategies (CHCS) Advisory Committee, as well as specific programs and grants, since CHCS’ inception in 1995

- Local approach – recruiting and hiring staff in the communities we serve
-

About the California Medicaid Managed Care Program

The Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) administers the state- and federally-funded Medi-Cal Medicaid program for certain groups of low- to moderate-income adults and children.

About the Medicaid Managed Care Program

Aetna Better Health of California was chosen by the DHCS to be one of the Medi-Cal Managed Care Health Plans to arrange for care and services by specialists, hospitals, and providers including member engagement, which includes outreach and education functions, grievances, and appeals.

Aetna Better Health of California is offered in both San Diego and Sacramento Counties.

Disclaimer

Providers are contractually obligated to adhere to and comply with all terms of the plan and your Aetna Better Health of California Provider Agreement, including all requirements described in this Manual, in addition to all federal and state regulations governing a provider. While this manual contains basic information about Aetna Better Health of California, DHCS requires that providers fully understand and apply DHCS requirements when administering covered services.

Please refer to www.dhcs.ca.gov/ for further information on DHCS.

Aetna Better Health of California Policies and Procedures

Our comprehensive and robust policies and procedures are in place throughout our entire Health Plan to verify all compliance and regulatory standards are met. Our policies and procedures are reviewed on an annual basis and updates are made as needed. All updates are communicated to both DHCS and providers/practitioners as needed via paper and/or electronic methods, such as but not limited to Provider Newsletter, Website or Secure Provider Portal.

Eligibility

To be eligible for Medi-Cal, a person must meet a categorical eligibility requirement, including but not limited to: Income –

Family Size	138% Poverty Level
1	\$16,754
2	\$22,715
3	\$28,677
4	\$34,638
5	\$40,600
6	\$46,562
7	\$52,523
8	\$58,485
Each additional person, add	\$5,962

- 65 or older
- Blind
- Disabled

- Under 21
- Pregnant
- In a skilled nursing or intermediate care home
- On refugee status for a limited time, depending how long you have been in the United States
- A parent or caretaker relative or a child under 21 if:
 - The child's parent is deceased or doesn't live with the child, or
 - The child's parent is incapacitated, or
 - The child's parent is under employed or unemployed
- Have been screened for breast and/or cervical cancer
- CalFresh
- SSI/SSP
- CalWORKs (AFDC)
- Refugee Assistance
- Foster Care or Adoption Assistance Program

Choosing a PCP

- Members need to pick a PCP that is in the Plan provider network.
- Each eligible family member does not have to have the same PCP.
- If a member does not pick a PCP, we will pick one for the member.
- Providers must verify eligibility every visit by the member.

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non-emergent, covered services. A member's assigned provider must also be verified prior to rendering primary care services.

When a member first enrolls in our Plan, we will do our best to make sure the member gets to keep the PCP they chose. Sometimes we cannot assign the member to the PCP they choose. When this happens, we will choose a PCP for the member. The PCP's name and phone number will be on the member's ID card. The member can call us at any time to change PCPs. We might choose a PCP for the member if:

- They did not choose a PCP when enrolled.
- The PCP they chose is not accepting new members
- The PCP they chose only sees certain members, such as Pediatricians.

If we must choose a PCP for a member, we will try to find a PCP that is close to the member residence and best fits their needs. We look for:

- The member's recent PCP
- The member's family member's PCP
- The member's zip code
- The member's age

ID Card

Members should present their ID card at the time of service.

The member ID card contains the following information:

- Member Name
- Member ID Number
- Date of Birth of Member
- Member's Gender
- PCP/IPA Name
- PCP/IPA Phone Number

- Effective Date of Eligibility
- Claims address
- Emergency Contact Information for Member
- Health Plan Name
- Aetna Better Health of California's Website

Sample ID Card Health Plan at Risk

Aetna Better Health® of California 

Medi-Cal

Name PACHECO, IZHAR

Member ID # 8F390875A **DOB** 01/01/2006 **Sex** M

PCP ABDULLAH, AL DWAIRI M

PCP Phone 1-530-342-4395 **Effective Date** 01/01/2018

AetnaBetterHealth.com/California

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.

MCCAMED1

Member Services/Servicios al Miembro: 1-855-772-9076, TTY 711, 24/7

Urgent Care: Call your primary care provider (PCP)

Atención de urgencia: Llame a su proveedor de cuidado primario (PCP)

Emergency Care: If you are having an emergency, call 911 or go to the closest hospital. You don't need preapproval for emergency transportation or emergency care in the hospital.

Atención de emergencia: Si tiene una emergencia, llame al 911 o vaya al hospital más cercano. No necesita aprobación previa para el transporte de emergencia o la atención de emergencia en el hospital.

Prior authorization is required for all inpatient admissions and selected outpatient services. To notify of an admission, please call 1-855-772-9076.

Se requiere **autorización previa** para todas las admisiones de internación y para ciertos servicios ambulatorios. Para notificar una admisión, llame al 1-855-772-9076.

Send medical claims to:
Aetna Better Health of California
P.O. Box 982971
El Paso, TX 79998-2971

To verify member eligibility:
1-855-772-9076
EDI Payor ID:
12BCA

CAMED1

Member Assigned to IPA

Aetna Better Health® of California 

Medi-Cal

Name ATEST, KYLIE

Member ID # 7A52364698 **DOB** 03/22/1988 **Sex** F

PCP ABDULLAH, AL DWAIRI M

PCP Phone 1-530-342-4395 **Effective Date** 09/21/2017

IPA RIVER CITY MEDICAL GROUP

IPA Phone 1-916-228-4300

AetnaBetterHealth.com/California

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.

MCCAIPA1

Member Services/Servicios al Miembro: 1-855-772-9076, TTY 711, 24/7

Urgent Care: Call your primary care provider (PCP)

Atención de urgencia: Llame a su proveedor de cuidado primario (PCP)

Emergency Care: If you are having an emergency, call 911 or go to the closest hospital. You don't need preapproval for emergency transportation or emergency care in the hospital.

Atención de emergencia: Si tiene una emergencia, llame al 911 o vaya al hospital más cercano. No necesita aprobación previa para el transporte de emergencia o la atención de emergencia en el hospital.

AetnaBetterHealth.com/California

CAIPA1

Model of Care

Integrated Care Management

Aetna Better Health of California's Integrated Care Management (ICM) Program uses a Bio-Psycho-Social (BPS) model to identify and reach our most vulnerable members. The approach matches members with the resources they need to improve their health status and to sustain those improvements over time. We use evidence-based practices to identify members at highest risk of not doing well over the next twelve (12) months and offer them intensive care management services built upon a collaborative relationship with a single clinical Case Manager, their caregivers and their Primary Care Provider (PCP). This relationship continues throughout the care management engagement. We offer members who are at lower risk supportive care management services. These include standard clinical care management and service coordination and support. Disease management is part of all care management services that we offer.

The ICM Interventions and Services are detailed below:

ICM Interventions and Services	
ICM Service Level	Care Management Interventions
<p>Intensive:</p> <p>Complex Case Management and Chronic Condition Management (Disease Management)</p>	<ul style="list-style-type: none"> • Outreach/Enrollment • Welcome Letter • Face to face visits • PCP notification of enrollment, education about the program and services and how they can best support their patient • Encouraging members to communicate with their care and service providers • Comprehensive bio-psychosocial assessment including behavioral health and substance abuse screening • Condition specific assessments for physical and behavioral health • Case Formulation/Synthesis (summary of the member's story) • Integrated plan of care and service plans (if member is LTSS eligible) • Chronic condition management • Member education and coaching to self-manage their conditions and issues • Monthly (minimum) care plan updates based on progress toward goals • Member contacts as clinically indicated and face to face if indicated • Complex care coordination with both internal and the member's multi disciplinary care team which includes the member's identified support system • Case rounds • Integrated care team meetings (duals & LTSS) • Bi-annual newsletter for primary chronic condition • Krames educational sheets

<p>Supportive:</p> <p>Supportive Standard Care Management and Chronic Condition Management (Disease Management)</p>	<ul style="list-style-type: none"> • Outreach/Enrollment • Welcome Letter • Face to face visits (LTSS only) • PCP notification of enrollment, education about the program and services and how they can best support their patient • Condition specific assessments for conditions of focus • Bio-psychosocial care plan which includes activities for chronic conditions and service plans • Chronic condition management • Coaching on the management of conditions and issues and self-care • Encouraging members to communicate with their care and service providers • Education on disease process, self-management skills, and adherence to recommended testing and treatment • Quarterly (minimum) care plan updates • Member contacts as clinically indicated • Care team coordination • Case rounds • Integrated care team meetings (duals & LTSS) • Bi-annual newsletter for primary chronic condition • Krames educational sheets
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ICM Interventions and Services	
ICM Service Level	Care Management Interventions
<p>Population Health</p> <p>Monitoring, follow up and education for low risk members</p>	<ul style="list-style-type: none"> • Low/No Risk pregnant members: Quarterly screening to identify risk factors • Dually enrolled Medicare-Medicaid: Annual Health Risk Questionnaire, low risk care plans, Krames materials • Welcome letter and bi-annual newsletter for low risk chronic condition management • Special populations: monitoring/tracking per state requirements • PCP notification of enrollment, education about the program and services and how they can best support their patient • Not applicable for LTSS

About this Provider Manual

This Provider Manual serves as a resource and outlines operations for Aetna Better Health of California’s Medi-Cal Health program. Through the Provider Manual, providers should be able to identify information on the majority of issues that may affect working with Aetna Better Health of California. Medical and other procedures are clearly denoted within the Manual.

Aetna Better Health of California’s Provider Manual is updated and made available to providers via the Aetna Better Health website at AetnaBetterHealth.com/California. Aetna Better Health of California annually notifies all new and existing participating providers in writing that the Provider Manual is available on the Aetna Better Health of California website, via provider/practitioner newsletter and or email. The Aetna Better Health of California Provider Manual is

available in hard copy form by contacting our Provider Services Department at **1-855-772-9076** or via email at **CaliforniaProviderRelationsDepartment@aetna.com**. Otherwise, for your convenience Aetna Better Health of California will make the Provider Manual available on our website at **[AetnaBetterHealth.com/California](https://www.aetna.com/betterhealth/california)**.

This manual is intended to be used as an extension of the Participating Health Provider Agreement, a communication tool and reference guide for providers and their office staff.

About Patient-Centered Medical Homes (PCMH)

A Patient-Centered Medical Home (PCMH), also referred to as a “health care home,” is an approach to providing comprehensive, high-quality, individualized primary care services where the focus is to achieve optimal health outcomes. The PCMH features a personal care clinician who partners with each member, their family, and other caregivers to coordinate aspects of the member’s health care needs across care settings using evidence-based care strategies that are consistent with the member’s values and stage in life. If you are interested in becoming a PCMH, please contact us at **1-855-772-9076**.

CHAPTER 2: CONTACT INFORMATION

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Providers who have additional questions can refer to the following phone numbers:

Important Contacts	Phone Number	Facsimile	Hours and Days of Operation (excluding State holidays)
Aetna Better Health of California	<p>1-855-772-9076 (follow the prompts in order to reach the appropriate departments)</p> <p>Provider Services Department</p> <p>Member Services Department (Eligibility Verifications, education, grievances)</p> <p>AetnaBetterHealth.com/California</p>	Individual departments are listed below	<p>8 AM - 5 PM PT Monday-Friday</p> <p>24 hours / 7 days per week</p> <p>Providers have access to Member Services staff and UM staff during normal business hours as well as after hours by dialing 1-855-772-9076.</p> <p>Should our staff need to initiate or return a call regarding UM issues; staff will identify themselves by name, title and organization name.</p>
Language Line	1-855-380-5345		Members have access to Services for Hearing Impaired (TTY) California Relay Services for Hearing- Impaired Members as well a Language Line if the member is in need of a translator.
Aetna Better Health of California – Care Management	<p>1-855-772-9076 Ask to be connected to the CM department</p>	Individual departments are listed below	
Aetna Better Health of California Medical Prior Authorization Department	<p>1-855-772-9076 Ask to be connected to the prior authorization department</p>	Individual departments are listed below	24 hours / 7 days per week

Aetna Better Health of California Compliance Hotline (Reporting Fraud, Waste or Abuse) Providers may remain anonymous.	1-855-321-3727	N/A	24 hours / 7 days per week through Voice Mail inbox
Aetna Better Health of California Special Investigations Unit (SIU) (Reporting Fraud, Waste or Abuse) Providers may remain anonymous.	1-800-338-6361	N/A	24 hours / 7 days per week

Aetna Better Health of California Department Fax Numbers	Fax Number
Member Services	1-844-453-1150
Provider Services	1-844-886-8349
Care Management	Sacramento 1-866-489-7441 San Diego 1-844-584-4450
Medical Prior Authorization	Sacramento 1-866-489-7441 San Diego 1-844-584-4450
Pharmacy Prior Authorization	Sacramento 1-866-489-7441 San Diego 1-844-584-4450

Community Resource	Contact Information
California Tobacco Quit line	1-800-NO-BUTTS (1-800-662-8887) Website: www.nobutts.org

Contractors	Phone Number	Facsimile	Hours and Days of Operation (excluding State holidays)
Interpreter Services Language interpretation services, including sign language, special services for the hearing impaired.	Please contact Member Services at 1-855-772-9076	N/A	24 hours / 7 days per week
Vision Vendor - VSP (Vision Service Plan)	1-800-877-7195	N/A	8 AM - 5 PM CT Monday-Friday

Lab – Quest Diagnostics (Preferred Lab) www.questdiagnostics.com	Please visit the website for additional information. www.questdiagnostics.com	Please visit the website for additional information. www.questdiagnostics.com	Please visit the website for additional information. www.questdiagnostics.com
Durable Medical Equipment- DME AetnaBetterHealth.com/California/find-provider	Please see our online provider search tool for details surrounding DME providers. 1-855-772-9076 (follow the prompts in order to reach the appropriate departments)	N/A	N/A

Agency Contacts & Important Contacts	Phone Number	Facsimile	Hours and Days of Operation (excluding State holidays)
California Department of Health Care Services (DHCS) – Medi-Cal 1-800-541-5555, TTY 711	916-449-5000	NA	Monday through Friday from 6:30 AM - 5 PM
Change Healthcare (Emdeon) Customer Service – EDI and Web Connect Email Support: hdsupport@webmd.com	1-877-363-3666 www.changehealthcare.com/	N/A	24 hours / 7 days per week
California Relay	1-800-735-2929 or 711	N/A	24 hours / 7 days per week

Reporting Suspected Neglect or Fraud			
The California Department of Social Services Child Abuse Hotline www.cdss.ca.gov/Reporting/Report-Abuse/Child-Abuse	Sacramento County 916-875-5437 San Diego County 1-858-560-2191 or 1-800-344-6000	NA	24 hours / 7 days per week
The National Domestic Violence Hotline	1-800-799-SAFE (7233) 1-800-787-3224 (TTY)	N/A	24 hours / 7 days per week

The California Medicaid Fraud Division of the Department of Health Care Services	1-800-822-6222		
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The Federal Office of Inspector General in the U.S. Department of Health and Human Services (Fraud)	1-800-HHS-TIPS (1-800-447-8477)		
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In addition to the telephone numbers above, participating providers may access the Aetna Better Health of California website 24 hours a day, 7 days a week at: [AetnaBetterHealth.com/California](https://www.aetna.com/betterhealth/california) for up-to-date information, forms and other resources such as:

- Provider quick reference guide
- Member rights and responsibilities
- Searchable provider directory
- Credentialing information
- Prior Authorization grid
- Clinical Practice Guidelines
- Adult and child preventive health guidelines
- Member handbook and benefits
- Appeals Information and forms
- Provider newsletters and educational articles
- Pharmacy formulary and Prior Authorization guidelines and forms
- Health and wellness materials and resources

CHAPTER 3: PROVIDER EXPERIENCE DEPARTMENT

Provider Experience Department Overview

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Our Provider Experience Department serves as a liaison between the Health Plan and the provider community. Our staff is comprised of Network Relations Representatives and Network Specialists. Our Network Relations Representatives conduct onsite provider training, problem identification and resolution, provider office visits, and accessibility audits.

Our Network Relations Representatives and Network Specialists are available by phone or email to provide telephonic or electronic support to all providers. Below are some of the areas where we may be able to provide assistance:

- Advise of an address change
- View recent updates
- Locate Forms
- Review member information
- Check member eligibility
- Find a participating provider or specialist
- Submitting prior authorizations
- Review or search the Preferred Drug List
- Notify the plan of a provider termination
- Notify the plan of changes to your practice
- Advise of a Tax ID or National Provider Identification (NPI) number change
- Obtain a secure web portal or member care Login ID
- Review claims or remittance advice

Our Provider Experience Department supports network development and contracting with multiple functions, including the evaluation of the provider network and compliance with regulatory network capacity standards. Our staff is responsible for the creation and development of provider communication materials, including the Provider Manual, Periodic Provider Newsletters, Bulletins, fax and/or email blasts, website notices, and the Provider Orientation information and Welcome Packet for new providers.

Provider Orientation

Aetna Better Health of California provides initial orientation for newly contracted providers **prior** to being placed on an active status with Aetna Better Health of California and before you see members. If you would like to view our orientation information, it can be found on our website or a digital version can be faxed or emailed to you if requested.

In follow up to initial orientation, Aetna Better Health of California provides a variety of provider educational forums for ongoing provider training and education, such as routine provider office visits, group or individualized training sessions on select topics (i.e. appointment time requirements, claims coding, appointment availability standards, member benefits, Aetna Better Health of California website navigation), distribution of Periodic Provider Newsletters and bulletins containing updates and reminders, and online resources through our website at

AetnaBetterHealth.com/California.

Provider Inquiries

Providers may contact us at **1-855-772-9076** between the hours of 8 AM and 5 PM, Monday through Friday, email us at CaliforniaProviderRelationsDepartment@aetna.com or access our secure provider web portal for any and all questions including checking on the status of an inquiry, claim, complaint, grievance and/or appeal. Our Provider Experience Team Staff will respond within 48 business hours.

Interested Providers

If you are interested in applying for participation in our Aetna Better Health of California network, please visit our website at AetnaBetterHealth.com/California, and complete the provider application (directions will be available online). If you would like to speak to a representative about the application process or the status of

your application, please contact our Provider Services Department at **1-855-772-9076**. To determine if Aetna Better Health of California is accepting new providers in a specific region, please contact our Provider Services Department at the number located above.

If you would like to mail your application, please mail to:

Aetna Better Health of California
Attention: Network Management Team
10260 Meanley Dr.
San Diego, CA 92131

Please note this is for all medical type of providers including HCBS, LTC, Ancillary, Hospital, etc.

CHAPTER 4: PROVIDER RESPONSIBILITIES & IMPORTANT INFORMATION

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Provider Responsibilities Overview

This section outlines general provider responsibilities; however, additional responsibilities are included throughout the Manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with all terms of the Medi-Cal Program, the Request for Proposal between DHCS and Aetna Better Health of California, and your Provider Agreement, and requirements outlined in this Manual. Aetna Better Health of California may or may not specifically communicate such terms in forms other than your Provider Agreement and this Manual.

Providers must cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, the Department of Health Care Services (DHCS), The California Medicaid Fraud Division of the Department of Health Care Services, Health and Human Services – Office of the Inspector General (HHS OIG), Federal Bureau of Investigation (FBI), Drug Enforcement Administration (DEA), Food and Drug Administration (FDA), and the U.S. Attorney's Office.

Providers must act lawfully in the scope of practice of treatment, management, and discussion of the medically necessary care and advising or advocating appropriate medical care with or on behalf of a member, including providing information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered including all relevant risk, benefits and consequences of non-treatment. Providers must also assure the use of the most current diagnosis and treatment protocols and standards. Advice given to potential or enrolled members should always be given in the best interest of the member. Providers may not refuse treatment to qualified individuals with disabilities, including but not limited to individuals with Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS).

Independent Practice Association (IPA)

Aetna Better Health has contracted with IPA's that make up a portion of our provider network. If you are part of an IPA, please remember to follow this Provider Manual and to contact your IPA should you have questions regarding any of the following:

- Credentialing
- Claims
- Patient Management
- Professional services, including billing and benefit coverage, unless specifically noted as Covered by the IPA

If you have any questions, please contact your IPA or Aetna Better Health's Provider Experience Department at **1-855-772-9076** or via email at californiaproviderrelationsdepartment@aetna.com.

Subcontractual Relationship and Delegation of Responsibilities

Regardless of the relationship that Aetna Better Health of California has with a subcontracted, IPAs, or delegates, whether direct or indirect through additional layers of contracting, Aetna Better Health of California hold ultimate responsibility for adhering to, and fully complying with all terms and conditions of the contract with the DHCS.

Unique Identifier/National Provider Identifier

Providers who provide services to Aetna Better Health of California members must obtain identifiers. Each provider is required to have a unique identifier, and qualified providers must have a National Provider Identifier (NPI) on or after the compliance date established by the Centers for Medicare and Medicaid Services (CMS).

Appointment Availability Standards

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the member's past and current medical history. Our Provider Experience Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. Providers are contractually required to meet the California Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, taking into account the urgency of and the need for the services.

Please note: Pursuant to Health & Safety Code § 1367.27(j)(2), if a provider who is not accepting new patients is contacted by a member or potential member seeking to become a new patient, the provider shall direct the member or potential member to both Aetna Better Health of California for additional assistance in finding a provider and to the department to report any inaccuracy with the plan's directory or directories.

The tables below show appointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologists (OB/GYNs), and high volume Participating Specialist Providers (PSPs).

Emergency	Urgent	Non-Urgent	Specialty	Ancillary Services
Emergent or emergency visits immediately upon presentation at the service delivery site. Emergency services must be available at all times.	Urgent Care for services that do not require prior authorization within forty-eight (48) hours; for services that do require prior authorization within ninety-six (96) hours. Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by Aetna Better Health of California through other arrangements.	Non-urgent sick care within 10 business days of request or sooner if medical condition(s) deteriorates into an urgent or emergency condition.	Specialty care consultation, including non-urgent, within 15 business days of request or as clinically indicated.	For the diagnosis or treatment of injury, illness, or other health condition, within 15 business days of request.

Prenatal Care: Members will be seen within the following timeframes:
<ul style="list-style-type: none"> • First prenatal visit within 10 business days
<ul style="list-style-type: none"> • Within their first trimester within 14 days
<ul style="list-style-type: none"> • Within the second trimester within 7 days
<ul style="list-style-type: none"> • Within their third trimester within 3 days
<ul style="list-style-type: none"> • High risk pregnancies within 3 days of identification of high risk by Medi-Cal or maternity care provider, or immediately if an emergency exists
<ul style="list-style-type: none"> • Physicals – This is regular care to keep you and your child healthy. Call your provider to make an appointment for preventive care. You can expect to be seen within ten business days. <ul style="list-style-type: none"> o Examples of preventive care are checkups, shots and follow up appointments.
<ul style="list-style-type: none"> • Mental health - You can expect to be seen by the provider within ten (10) business days

In office, waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room. If a provider is delayed, patients must be notified immediately. If the

wait is anticipated to be more than 90 minutes, the patient must be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.

Please note that follow-up to ED visits must be in accordance with ED attending provider discharge instructions.

Telephone Accessibility Standards

Providers have the responsibility to make arrangements for after-hours coverage in accordance with applicable state and federal regulations, either by being available, or having on-call arrangements in place with other qualified participating Aetna Better Health of California providers for the purpose of rendering medical advice, determining the need for emergency and other after-hours services including, authorizing care and verifying member enrollment with us.

It is our policy that network providers cannot substitute an answering service as a replacement for establishing appropriate on-call coverage. On-call coverage response for routine, urgent, and emergent health care issues are held to the same accessibility standards regardless if after-hours coverage is managed by the PCP, current service provider, or the on-call provider.

All providers must have a published after-hours telephone number and maintain a system that will provide access to primary care 24 hours a day, 7 days a week. In addition, we will encourage our providers to offer open access scheduling, expanded hours and alternative options for communication (e.g., scheduling appointments via the web, communication via email) between members, their PCPs, and practice staff. Providers must return calls within 30 minutes. We will routinely measure the PCP's compliance with these standards as follows:

- Our medical and provider management teams will continually evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after-hours access or if a member may need care management intervention.
- Our compliance and provider management teams will evaluate member, caregiver, and provider grievances regarding after-hour access to care to determine if a PCP is failing to comply on a monthly basis.

Providers must comply with telephone protocols for all of the following situations:

- Answering the member telephone inquiries on a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by a member
- Identifying and rescheduling broken and no-show appointments
- Identifying special member needs while scheduling an appointment (e.g., wheelchair and interpretive/linguistic needs)
- Triage for medical and dental conditions and special behavioral needs for noncompliant individuals who are mentally deficient. Triage is defined as a process for assessing a member's needs and determining the appropriate level and type of service.

A telephone response should be considered acceptable/unacceptable based on the following criteria:

Acceptable – An active provider response, such as:

- Telephone is answered by provider, office staff, answering service, or voice mail.
- The answering service either:
 - Connects the caller directly to the provider
 - Contacts the provider on behalf of the caller and the provider returns the call
 - Provides a telephone number where the provider/covering provider can be reached
- The provider's answering machine message provides a telephone number to contact the

provider/covering provider.

Unacceptable:

- The answering service:
 - Leaves a message for the provider on the PCP's/covering provider's answering machine
 - Responds in an unprofessional manner
- The provider's answering machine message:
 - Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergent situations.
 - Instructs the caller to leave a message for the provider.
- No answer
- Listed number no longer in service
- Provider no longer participating in the contractor's network
- On hold for longer than ten (10) minutes
- Answering Service refuses to provide information for after-hours survey
- Telephone lines persistently busy despite multiple attempts to contact the provider

Provider must make certain that their 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.

In the event that a PCP fails to meet telephone accessibility standards, a Provider Services Representative will contact the provider to inform them of the deficiency, educate the provider regarding the standards, and work to correct the barrier to care.

Annual Network Certification

Federal and state laws and regulations require DHCS to certify that Aetna Better Health of California has the capacity to serve our members. As part of that certification, Aetna Better Health of California will demonstrate that we are contracted with the required number and mix of primary and specialty care providers, and that we are able to provide medically necessary services needed for 100% of anticipated membership and utilization. Specifically, Aetna Better Health of California will ensure we and our subcontractor IPA's network includes the following:

- Adult and pediatric PCPs. Including non-physician medical practitioners
- Obstetrician-gynecologists (OB/GYN)
- Adult and pediatric core specialists
- Adult and pediatric mental health providers
- Hospitals
- Pharmacies
- Ancillary services
- Federally Qualified Health Centers (FQHC) and/or Rural Health Center (RHC)
- Freestanding Birth Centers

Aetna Better Health of California is required to have a network with the capacity to serve 100% of eligible members in each county and will adjust the number of network providers proportionally to accommodate any changes in enrollment. At a minimum, Aetna Better Health of California must meet the full time equivalent (FTE) ratios of one FTE PCP to every 2,000 members and one FTE physician for every 1,200 members. Additionally, Aetna Better Health of California will provide Specialty Mental Health Services in compliance with mental health parity requirements.

Aetna Better Health of California will ensure providers comply with time and distance standards and service availability, physical accessibility, out of network access, timely access, continuity of care and language assistance requirements as described in APL 20-003 and will conduct monthly Timely Access Surveys to ensure providers meet these requirements. Provider education and/or a corrective action plan will be provided

to any providers who do not meet the any of the requirements listed above. In the case that Aetna Better Health of California is unable to meet time and distance standards and has exhausted all reasonable contracting options with nearer providers, alternative access providers will be identified to meet the specific needs of the member(s).

Covering Providers

Our Provider Services Department must be notified if a covering provider is not contracted or affiliated with Aetna Better Health of California. This notification must occur in advance of providing authorized services. Depending on the Program, reimbursement to a covering provider is based on the fee schedule. If members have other insurance coverage, providers must submit a paper or electronic bill and primary carrier EOB for reimbursement. Medicaid is always payor of last result. Failure to notify our Provider Services Department of covering provider affiliations or other insurance coverage may result in claim denials and the provider may be responsible for reimbursing the covering provider.

Verifying Member Eligibility

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non-emergent, covered services. A member's assigned provider must also be verified prior to rendering primary care services. Providers are NOT reimbursed for services rendered to members who lost eligibility or who were not assigned to the primary care provider's panel (unless she/he is a physician covering for the provider).

Member eligibility can be verified through one of the following ways:

- **Telephone Verification:** Call our Member Services Department to verify eligibility at **1-855-772-9076**. To protect member confidentiality, providers are asked for at least three pieces of identifying information such as the member's identification number, date of birth and address before any eligibility information can be released.
- **Secure Website Portal:** Contact our Provider Services Department for additional information about securing a confidential password to access the site.
- **Monthly Roster:** Monthly rosters are found on the Secure Website Portal.
 - Note: rosters are only updated once a month.

Provider Secure Web Portal

The Secure Web Portal is a web-based platform that allows us to communicate member healthcare information directly with providers. Providers can perform many functions within this web-based platform. The following information can be attained from the Secure Web Portal:

- Member Eligibility Search – Verify current eligibility of one or more members.
- Panel Roster – View the list of members currently assigned to the provider as the PCP.
- Provider List – Search for a specific provider by name, specialty, or location.
- Claims Status Search – Search for provider claims by member, provider, claim number, or service dates. Only claims associated with the user's account provider ID will be displayed.
- Clinical Practice Guidelines.
- Preventive health guidelines (adult and child).
- Provider manual.
- Remittance Advice Search – Search for provider claim payment information by check number, provider, claim number, or check issue/service dates. Only remits associated with the user's account provider ID will be displayed.
- Provider Prior Authorization Look up Tool – Search for provider authorizations by member, provider, authorization data, or submission/service dates. Only authorizations associated with the user's account provider ID will be displayed. The tool will also allow providers to:
 - Search Prior Authorization requirements by individual or multiple Current Procedural Terminology/Healthcare Common Procedures Coding System (CPT/HCPCS) codes simultaneously
 - Review Prior Authorization requirement by specific procedures or service groups

- Receive immediate details as to whether the code(s) are valid, expired, a covered benefit, have prior authorization requirements, and any noted prior authorization exception information
- Export CPT/HCPS code results and information to Excel
- Ensure staff works from the most up-to-date information on current prior authorization requirements
- Submit Authorizations – Submit an authorization request online. Three types of authorization are available:
 - Medical Inpatient services including surgical and non-surgical, rehabilitation and hospice
 - Outpatient
 - Durable Medical Equipment – Rental
 - Non-Par providers must receive prior authorization for all treatment
- Healthcare Effectiveness Data and Information Set (HEDIS) – Check the status of the member’s compliance with any of the HEDIS measures. A “Yes” means the member has measures that they are not compliant with; a “No” means that the member has met the requirements.

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website.

Member Care Web Portal

The Member Care Web Portal is another web-based platform offered by Aetna Better Health of California that allows providers access to the member’s care plan, other relevant member clinical data, and securely interact with Care Management staff.

Providers are able to do the following via the Member Care Web Portal:

For their Practice:

- Providers can view their own demographics, addresses, and phone and fax numbers for accuracy.
 - Providers can update their own fax number and email addresses. For their patients:
- View and print member’s care plan* and provide feedback to Case Manager via secure messaging.
- View a member’s profile which contains:
 - Member’s contact information
 - Member’s demographic information
 - Member’s Clinical Summary
 - Member’s Gaps in Care (individual member)
 - Member’s Care Plan
 - Member’s Service Plans
 - Member’s Assessments responses*
 - Member’s Care Team: List of member’s Health Care Team and contact information (e.g., specialists, caregivers)*, including names/relationship
 - Detailed member clinical profile: Detailed member information (claims-based data) for conditions, medications, and utilization data with the ability to drill-down to the claim level*
 - High-risk indicator* (based on existing information, past utilization, and member rank)
 - Conditions and Medications reported through claims
 - Member reported conditions and medications* (including Over the Counter (OTC), herbals, and supplements)
- View and provide updates and feedback on “HEDIS Gaps in Care” and “Care Consideration” alerts for their member panel*
- Secure messaging between provider and Case Manager
- Provider can look up members not on their panel (provider required to certify treatment purpose as justification for accessing records)

Any member can limit provider access to clinical data except for members flagged for 42 C.F.R. Part 2 (substance abuse). They must sign a disclosure form and list specific providers who can access their

clinical data.

For additional information regarding the Member Care Web Portal, please access the Member Care Web Portal Navigation Guide located on our website.

Preventive or screening services

Providers are responsible for providing appropriate preventive care to members. These preventive services include, but are not limited to:

- Age-appropriate immunizations, disease risk assessment and age-appropriate physical examinations.
- Well woman visits (female members may go to a network obstetrician/gynecologist for a well woman exam once a year without a referral).
- Age and risk appropriate health screenings.
- Dental screening and topical application of fluoride
(Effective on and after June 1, 2006, topical application of fluoride for children less than 6 years of age, up to three times in a 12 month period, is a Medi-Cal Managed Care Plan benefit. When the procedure follows a protocol established by the attending physician, then nurses and other appropriate personnel may apply fluoride varnish.)

Health Education

A number of health education tools, resources and materials are available at no cost for providers to share with and educate members about including:

- The MyActiveHealth tool can be accessed by members through their patient portal or the ABHCA website and provides members with interactive tools about a number of different health issues and conditions. The ABHCA health educator can provide an orientation about MyActiveHealth to providers and their staff and members upon request.
- Member Newsletters are provided to all members on a quarterly basis and are mailed to their homes and contain health tips and information about a variety of health topics. ABHCA has extra copies of newsletters that can be provided upon request. Members diagnosed with certain chronic conditions will also receive an additional newsletter specific to that condition.
- The ABHCA website Health and Wellness section contains information about specific health topics, links to Krames Health Sheets, and information about the latest ABHCA health education classes and classes and resources available in the community.

Educating members on their own health care

Aetna Better Health of California does not prohibit providers from acting within the lawful scope of their practice and encourages them to advocate on behalf of a member and to advise them on:

- The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
- Any information the member needs in order to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The member's right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment, and to express preferences about future treatment decisions

Practitioners / providers may freely communicate with members on items such as these regardless of benefit coverage limitations.

Emergency Services

Authorizations are not required for emergency services. In an emergency, please advise the member to go to the nearest emergency department. If a provider is not able to provide services to a member who needs urgent or emergent care, or if they call after hours, the member should be referred to the closest in-network urgent care or emergency department.

Urgent Care Services

As the provider, you must serve the medical needs of our members; you are required to adhere to the all appointment availability standards. In some cases, it may be necessary for you to refer members to one of our network urgent care centers (after hours in most cases). Please reference the “Find a Provider” link on our website and select an “Urgent Care Facility” in the specialty drop down list to view a list of participating urgent care centers located in our network.

Periodically, Aetna Better Health of California will review unusual urgent care and emergency room utilization. Trends will be shared and may result in increased monitoring of appointment availability.

Primary Care Providers (PCPs)

The primary role and responsibilities of PCPs include, but are not be limited to:

- Provide or arrange for urgent covered services as defined in your contract, including emergency medical services, to members on 24 hours per day, seven days per week basis.
- Providing primary and preventive care and acting as the member’s advocate.
- Initiating, supervising, and coordinating referrals for specialty care and inpatient services, maintaining continuity of member care, and including, as appropriate, transitioning young adult members from pediatric to adult providers.
- Maintaining the member’s medical record.
- Providing to Members:
 - Office visits during regular office hours
 - Office visits or other services during non-office hours as determined to be medically necessary
 - Response to phone calls within a reasonable time and on an on-call basis 24 hours per day, seven days per week

Primary Care Providers (PCPs) are responsible for rendering, or ensuring the provision of, covered preventive and primary care services for our members. These services will include, at a minimum, the treatment of routine illnesses, immunizations, health screening services, and maternity services, if applicable.

Primary Care Providers (PCPs) in their care coordination role serve as the referral agent for specialty and referral treatments and services provided to members assigned to them and attempt to verify coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

- Referring members to behavioral health providers, providers or hospitals within our network, as appropriate, and if necessary, referring members to out-of-network specialty providers
- Coordinating with our Prior Authorization Department with regard to prior authorization procedures for members
- Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers and hospitals
- Coordinating the medical care for the programs the member is assigned to, including at a minimum:
 - Oversight of drug regimens to prevent negative interactive effects
 - Follow-up for all emergency services
 - Coordination of inpatient care
 - Coordination of services provided on a referral basis
 - Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs

Primary Care Providers (PCPs) are responsible for establishing and maintaining hospital admitting privileges that are sufficient to meet the needs of members or entering into formal arrangements for management of inpatient hospital admissions of members. This includes arranging for coverage during leave of absence periods with an in-network provider with admitting privileges.

Specialty Providers

Specialty providers are responsible for providing services in accordance with the accepted community standards of care and practices. Specialists should provide services to members upon receipt of a written referral form from the member's PCP or from another Aetna Better Health of California participating specialist. Specialists are required to coordinate with the PCP when members need a referral to another specialist. The specialist is responsible for verifying member eligibility prior to providing services.

When a specialist refers the member to a different specialist or provider, then the original specialist must share these records, upon request, with the appropriate provider or specialist. The sharing of the documentation should occur with no cost to the member, other specialists, or other providers.

Primary Care Providers (PCPs) should only refer members to Aetna Better Health of California network specialists. If the member requires specialized care from a provider outside of our network, a prior authorization is required.

Specialty Providers Acting as PCPs

In limited situations, a member may select a physician specialist to serve as their PCP. In these instances, the specialist must be able to demonstrate the ability to provide comprehensive primary care. A specialist may be requested to serve as a PCP under the following conditions:

- When the member has a complex, chronic health condition that requires a specialist's care over a prolonged period and exceeds the capacity of the non-specialist PCP (i.e., members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.)
- When a member's health condition is life threatening or so degenerative and disabling in nature to warrant a specialist serve in the PCP role.
- In unique situations where terminating the clinician-member relationship would leave the member without access to proper care or services or would end a therapeutic relationship that has been developed over time leaving the member vulnerable or at risk for not receiving proper care or services.

Aetna Better Health of California's Chief Medical Officer (CMO) will coordinate efforts to review the request for a specialist to serve as PCP. The CMO will have the authority to make the final decision to grant PCP status taking into consideration the conditions noted above.

Specialty providers acting as PCPs must comply with the appointment, telephone, and after-hours standards noted in Chapter 2. This includes arraigning for coverage 24 hours a day, 7 days a week.

PCP Panel Size

In order to better serve our Medi-Cal members, Aetna Better Health of California has established PCP panel sizes. Aetna Better Health of California has structures and processes in place to ensure the following full-time provider to member ratios:

- Primary Care Physicians - 1:2,000
- Total Physicians – 1:1,200
- Individual Non-Physician Medical Practitioner – 1:1,000
 - Nurse Practitioners – 1:4
 - Physicians – 1:2

Self-Referrals/Direct Access

Members may self-refer/directly access some services without an authorization from their PCP. These services include behavioral health care, vision care, adult dental care, minor consent services, family planning, and services provided by Women's Health Care Providers (WHCPs). The member must obtain these self-referred services from an Aetna Better Health of California provider.

Family planning services do not require prior authorization. Members may access family planning services from any qualified provider (note: It can be par or non-par; we do not restrict family planning services). Members also have direct access to WHCP services. Members have the right to select their own WHCP, including nurse midwives who participate in Aetna Better Health of California's network, and can obtain maternity and gynecological care without prior approval from a PCP.

Skilled Nursing Facility (SNF) Providers

Nursing Facilities (NF), Skilled Nursing Facilities (SNFs), or Nursing Homes provide services to members that need consistent care, but do not have the need to be hospitalized or require daily care from a physician. Many SNFs provide additional services or other levels of care to meet the special needs of members.

Long Term Care Providers

Long Term care providers are responsible for providing services in accordance with the accepted community standards of care and practices. The long-term care provider is responsible for verifying member eligibility prior to providing services.

When a long-term care provider refers the member to a different long-term care provider, then the original long-term care provider must share these records, upon request, with the appropriate provider or long-term care provider. The sharing of the documentation should occur with no cost to the member, other long-term care provider, or other providers.

Home and Community Based Services (HCBS)

Home and Community Based Providers are obligated to work with Aetna Better Health of California case managers. Case managers will complete face-to-face assessments with our members, in their residence, at least every 90 days. Based on the assessment, case managers will then identify the appropriate services that meet the member's functional needs; including determining which network provider may be available in order to provide services to the member in a timely manner. Upon completion, the case managers will then create authorizations for the selected Provider and fax/email these authorizations accordingly. Case managers will also follow up with the member the day after services were to start to confirm that the selected Provider started the services as authorized.

There may be times when an interruption of service may occur due to an unplanned hospital admission or short-term nursing home stay for the member. While services may have been authorized for caregivers and agencies, providers should not be billing for any days that fall between the admission date and the discharge date or any day during which services were not provided. This could be considered fraudulent billing.

Example:

Member is authorized to receive 40 hours of personal assistant per week over a 5-day period. The member is receiving 8 hours of care a day.

The member is admitted into the hospital on January 1 and is discharged from the hospital on January 3. There should be no billable hours for January 2, as no services were provided on that date since the member was hospital confined for a full 24 hours.

Caregivers would not be able or allowed to claim time with the member on the example above, since no services could be performed on January 2. This is also true for any in-home service.

Personal assistants and community agencies are responsible for following this process. If any hours are submitted when a member has been hospitalized for the full 24 hours, the personal assistants and agencies will be required to pay back any monies paid by Aetna Better Health of California. Aetna Better Health of California will conduct periodic audits to verify this is not occurring.

Home and Community Based Services (HCBS) in Assisted Living Facilities

The OIG published this report in December 2012:

HOME AND COMMUNITY BASED SERVICES IN ASSISTED LIVING FACILITIES, OEI-09-08-00360

OIG recommend that CMS issue guidance to State Medicaid programs emphasizing the need to comply with Federal requirements for covering HCBS under the 1915(c) waiver. CMS concurred with our recommendation. CMS has also published expectations regarding person-centered plans of care and to provide characteristics of settings that are not home and community-based to verify state compliance with the statutory provisions of section 1915(c) of the Act.

What this means for residential HCBS providers such as assisted living facilities is summarized as follows:

- A focus on quality of services provided
- An Individualized Person-Centered Care Plan
- A community integration goal planning process
- The right to receive home and community-based services in a home-like environment

As a result, Aetna Better Health of California may take interventions or remediation steps that the state would expect to see. Aetna Better Health of California will work with the Assisted Living Facilities (ALF) administrators and staff to correct any identified deficiencies within a timeframe mandated by the state. The following are some examples of such interventions or remediation steps Aetna Better Health of California may implement upon discovery that an ALF is not maintaining a home-like environment:

- Aetna Better Health of California will not refer new Nursing Home Diversion members to the non-compliant ALF until outstanding deficiencies are resolved.
- Aetna Better Health of California will terminate from its network ALFs that consistently fail to exhibit home like characteristics and that do not resolve outstanding issues.
- As a last resort, Aetna Better Health of California may counsel a member who is not residing in a home-like environment that he/she will not be able to continue to receive home and community-based waiver services in a non-compliant facility. If the individual wishes to remain in the ALF, he/she may face disenrollment.
- If Aetna Better Health of California terminates a contract with an ALF, and the member agrees to move to a different ALF, Aetna Better Health of California would facilitate transferring the member to an ALF that meets the home-like environment requirements.

Residential facility providers agree to comply with the home-like environment and community integration language provided by the State. Such language is included in your provider agreement. All providers must also comply with the applicable Resident Bill of Rights and attest to being in compliance as part of the monitoring and credentialing process. Incorporated in this handbook is the Home and Community Based Assessment Tool used by Aetna Better Health of California in support of the verbatim wording in the ALF and AFCH provider agreements as follows:

Assisted Living Facilities (ALF) and Adult Family Care Homes (AFCH) must maintain Home-Like Environment (HLE) (also known as Home and Community Based or HCB) characteristics according to Mandates.

Additionally, waiver members residing in assisted living facilities and other residential care facilities must be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

- Private or semi-private rooms
- Roommate for semi-private rooms
- Locking door to living unit
- Access to telephone and length of use
- Eating schedule
- Participation in facility and community activities

Ability to have:

- Unlimited visitations
- Snacks as desired

Ability to:

- Prepare snacks as desired and maintain personal sleeping schedule

Home Delivered Nutrition Program Providers

Adults 60 and older who are homebound due to illness or disability can ask to have meals delivered to them if they are registered with a County of San Diego nutrition provider that offers this service. Once a request for a home-delivered meal is made, a representative from the nutrition program will visit the older adult to assess the need. If appropriate for the program, a hot meal is delivered each weekday and frozen meals are provided for the weekends. Follow up assessments are required on a quarterly basis to ensure the senior still qualifies for the program. Not all cities are covered by the County's nutrition program, so please check the program availability in your area:

www.sandiegocounty.gov/content/sdc/hhsa/programs/ais/nutrition_services/home_delivered_meals.html

Out of Network Providers

When a member with a special need for services is not able to be served through a contracted provider, Aetna Better Health of California will authorize service through an out-of-network provider agreement. Our Medical Management team will arrange care by authorizing services to an out-of-network provider and facilitating transportation through the medical transportation vendor when there are no providers that can meet the member's special need available in a nearby location. If needed, our Provider Services Department will negotiate a Single Case Agreement (SCA) for the service and refer the provider to our Network Development team for recruitment to join the provider network. The member may be transitioned to a network provider when the treatment or service has been completed or the member's condition is stable enough to allow a transfer of care.

Second Opinions

A member may request a second opinion from a provider within our network. Providers should refer the member to another network provider within an applicable specialty for the second opinion. Please note that there are no timeframes for referrals. If an Aetna Better Health of California provider is not available, Aetna Better Health of California will help the member get a second opinion from a non-participating provider at no cost to the member.

Provider Requested Member Transfer

When persistent problems prevent an effective provider-patient relationship, a participating provider may ask an Aetna Better Health of California 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 termination:

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 of California
Provider Services Manager
10260 Meanley Dr.
San Diego, CA 92131
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 will 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 a PCP, Aetna Better Health of California will work with the member to inform him/her on how to select another primary care provider.

Facility Site Review

State law requires all Primary Care Provider (PCP) sites have the capacity to support the safe and effective provision of primary care services. To ensure compliance, Aetna Better Health of California will perform initial and subsequent site reviews, consisting of a Facility Site Review (FSR) and a Medical Record Review (MRR) using the tools and standards set forth by our regulators. FSRs and MRRs will be supervised and certified by Aetna Better Health of California's Certified Master Trainer and Certified Site Reviewers and other certified professional staff that may be delegated to perform these reviews per DHCS tools and standards. Each PCP site must pass an initial FSR prior to being added to the network or having members assigned to them, and each individual PCP and must pass an initial MRR after the PCP is assigned members. Additionally, PCPs must pass subsequent reviews consisting of both FSR and MRR at least every 3 years. Once a FSR is completed, Aetna Better Health of California will issue a Certified Quality Provider Site certificate that is valid for up to three years. Providers will be notified in advance for scheduled site reviews.

Medical Records Review

Aetna Better Health of California's standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within the Aetna Better Health of California provider network. Below is a list of Aetna Better Health of California medical record review criteria. Consistent organization and documentation in patient medical records is required as a component of the Aetna Better Health of California Quality Management (QM) initiatives to maintain continuity and effective, quality patient care.

Provider records must be maintained in a legible, current, organized, and detailed manner that permits effective patient care and quality review. Providers must make records pertaining to Aetna Better Health of California members immediately and completely available for review and copying by the Department and federal officials at the provider's place of business, or forward copies of records to the Department upon written request without charge.

Medical records must reflect the different aspects of patient care, including ancillary services. The member's medical record must be legible, organized in a consistent manner and must remain confidential and accessible to authorized persons only.

All medical records, where applicable and required by regulatory agencies, must be made available electronically.

All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements:

- Member identification information on each page of the medical record (i.e., name, Medicaid Identification Number)
- Documentation of identifying demographics including the member's name, address, telephone number, employer, Medicaid Identification Number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative
- Complying with all applicable laws and regulations pertaining to the confidentiality of member medical records, including, but not limited to obtaining any required written member consents to disclose confidential medical records for complaint and appeal reviews
- Initial history for the member that includes family medical history, social history, operations, illnesses, accidents and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member)

- Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received
- Immunization records (recommended for adult members if available)
- Dental history if available, and current dental needs and services
- Current problem list (The record will contain a working diagnosis, as well as a final diagnosis and the elements of a history and physical examination, upon which the current diagnosis is based. In addition, significant illness, medical conditions, and health maintenance concerns are identified in the medical record.)
- Patient visit data - Documentation of individual encounters must provide adequate evidence of, at a minimum:
 - History and physical examination - Appropriate subjective and objective information is obtained for the presenting complaints
 - Plan of treatment
 - Diagnostic tests
 - Therapies and other prescribed regimens
 - Follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call, or visit. Specific time to return is noted in weeks, months, or as needed. Unresolved problems from previous visits are addressed in subsequent visits
 - Referrals, recommendations for specialty, behavioral health, dental and vision care, and results thereof
 - Other aspects of patient care, including ancillary services
- Fiscal records - Providers will retain fiscal records relating to services they have rendered to members, regardless of whether the records have been produced manually or by computer
- Recommendations for specialty care, as well as behavioral health, dental and vision care and results thereof
- Current medications (Therapies, medications and other prescribed regimens - Drugs prescribed as part of the treatment, including quantities and dosages, will be entered into the record. If a prescription is telephoned to a pharmacist, the prescriber's record will have a notation to the effect.)
- Documentation, initialed by the member's PCP, to signify review of:
 - Diagnostic information including:
 - Laboratory tests and screenings
 - Radiology reports
 - Physical examination notes
 - Other pertinent data
- Reports from referrals, consultations and specialists
- Emergency/urgent care reports
- Hospital discharge summaries (Discharge summaries are included as part of the medical record for (1) hospital admissions that occur while the patient is enrolled in Aetna Better Health of California and (2) prior admissions as necessary.)
- Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed, and behavioral health history
- Documentation as to whether or not an adult member has completed advance directives and location of the document (California advance directives include Living Will, Health Care Power of Attorney, and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of health care when the individual is incapacitated.)
- Documentation related to requests for release of information and subsequent releases
- Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care
- Entries - Entries will be signed and dated by the responsible licensed provider. The responsible licensed provider will countersign care rendered by ancillary personnel. Alterations of the record will be signed and dated

- Provider identification - Entries are identified as to author
- Legibility – Again, the record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.

Medical Record Audits

Aetna Better Health of California, DHCS or its appointed authority, or CMS may conduct routine medical record audits to assess compliance with established standards including the completion of the Initial Health Assessment (IHA) within 120 days of member’s enrollment. Medical records may be requested when we are responding to an inquiry on behalf of a member or provider, administrative responsibilities or quality of care issues. Providers must respond to these requests promptly within thirty (30) days of request. Medical records must be made available to DHCS for quality review upon request and free of charge.

Access to Facilities and Records

Providers are required to retain and make available all records pertaining to any aspect of services furnished to a member or their contract with Aetna Better Health of California for inspection, evaluation, and audit for the longer of:

- A period of seven (7) years from the date of service; or
- Seven (7) years after final payment is made under the provider’s agreement and all pending matters are closed.

Documenting Member Appointments

When scheduling an appointment with a member over the telephone or in person (i.e. when a member appears at your office without an appointment), providers must verify eligibility and document the member’s information in the member’s medical record. You may access our website to electronically verify member eligibility or call the Member Services Department at **1-855-772-9076**.

Missed or Cancelled Appointments

Providers must:

- Document in the member’s medical record, and follow-up on missed or canceled appointments, including missed EPSDT appointments.
- Conduct an affirmative outreach to a member who misses an appointment by performing the minimum reasonable efforts to contact the member in order to bring the member’s care into compliance with the standards.
- Notify our Member Services Department when a member continually misses appointments.

Documenting Referrals

Providers are responsible for initiating, coordinating, and documenting referrals to specialists, including dentists and behavioral health specialists within our network. Providers must follow the respective practices for emergency room care, second opinion, and noncompliant members.

Confidentiality and Accuracy of Member Records

Providers must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies an Aetna Better Health of California member. Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas.

Specifically, our network providers must:

- Maintain accurate medical records and other health information.
- Help verify timely access by members to their medical records and other health information.
- Abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, other health information, and member information.

Providers must follow both required and voluntary provision of medical records and must be consistent with

the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations (www.hhs.gov/ocr/privacy/).

Health Insurance Portability and Accountability Act of 1997 (HIPAA)

The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy and security provisions. HIPAA impacts what is referred to as covered entities; specifically, providers, health plans, and health care clearinghouses that transmit health care information electronically. HIPAA established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit www.hhs.gov/ocr/hipaa/. In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records, confidential provider, and member information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:

- Train your staff on HIPAA
- Consider the patient sign-in sheet
- Keep patient records, papers and computer monitors out of view
- Have electric shredder or locked shred bins available

The following member information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information Protected Health Information (PHI). The Privacy Rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
- "Individually identifiable health information" is information, including demographic data, that relates to:
 - The individual's past, present or future physical or mental health, or condition.
 - The provision of health care to the individual.
 - The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
 - Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).
 - Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health of California.
 - Release of data to third parties requires advance written approval from the Department, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by members or releases required by court order, subpoena, or law.

Additional privacy requirements are located throughout this Manual. Please review the "Medical Records" section for additional details surrounding safeguarding patient medical records. For additional training or Q&A, please visit the following site at <http://aspe.hhs.gov/admsimp/final/pvcguide1.htm>.

Member Privacy Rights

Aetna Better Health of California's privacy policy states that members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements.

Our privacy policy conforms with 45 C.F.R. (Code of Federal Regulations): relevant sections of the HIPAA that provide member privacy rights and place restrictions on uses and disclosures of protected health information

(§164.520, 522, 524, 526, and 528).

Our policy also assists Aetna Better Health of California personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise privacy rights through privacy request, including:

- Making information available to members or their representatives about Aetna Better Health of California's practices regarding their PHI.
- Maintaining a process for members to request access to, changes to, or restrictions on, disclosure of their PHI.
- Providing consistent review, disposition, and response to privacy requests within required time standards.
- Documenting requests and actions taken.

Member Privacy Requests

Members may make the following requests related to their PHI ("privacy requests") in accordance with federal, state, and local law:

- Make a privacy complaint
- Receive a copy of all or part of the designated record set
- Amend records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI
- Receive confidential communications
- Receive a Notice of Privacy Practices

A privacy request must be submitted by the member or member's authorized representative. A member's representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the member or the deceased member's estate. Except for requests for a health plan Notice of Privacy Practices, requests from members or a member's representative must be submitted to Aetna Better Health of California in writing.

Sensitive Services

Aetna Better Health and its contracted providers and Subcontractors are required to take specific steps to protect the confidentiality of a subscriber's or enrollee's medical information to include but not limited to direct communications regarding protected individual's receipt of sensitive services directly to the protected individual receiving care as follows:

- Directly to the protected individual's designated alternative mailing address,
- Email address, or
- Telephone number or

In the absence of the alternative, to the address or telephone number on file in the name of the protected individual.

All such communications shall include the following written, verbal, or electronic communications related to the receipt of sensitive services:

- Bills and attempts to collect payment
- An explanation of benefits notice
- A notice of adverse benefits determinations
- Request for additional information regarding a claim
- A notice of a contested claim
- The name and address of a provider, description of services provided, and other information related to a visit

Any written, oral or electronic communication from the plan that contains protected health information.

Cultural Competency

Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Aetna Better Health of California expects providers to treat all members with dignity and respect as required by federal law including honoring member's beliefs, be sensitive to cultural diversity, and foster respect for member's cultural backgrounds. Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

Aetna Better Health of California has developed effective provider education programs that encourage respect for diversity, foster skills that facilitate communication within different cultural groups and explain the relationship

between cultural competency and health outcomes. These programs provide information on our members' diverse backgrounds, including the various cultural, racial, and linguistic challenges that members encounter, and we develop and implement proven methods for responding to those challenges.

Providers receive education about such important topics as:

- The reluctance of certain cultures to discuss mental health issues and of the need to proactively encourage members from such backgrounds to seek needed treatment
- The impact that a member's religious and cultural beliefs can have on health outcomes (e.g., belief in non-traditional healing practices).
- The problem of health illiteracy and the need to provide patients with understandable health information (e.g., simple diagrams, communicating in the vernacular, etc.)
- History of the disability rights movement and the progression of civil rights for people with disabilities.
- Physical and programmatic barriers that impact people with disabilities accessing meaningful care

Health Literacy – Limited English Proficiency (LEP) or Reading Skills

In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and State requirements, Aetna Better Health of California is required to verify that Limited English Proficient (LEP) members have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Providers are required to treat all members with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all members, including:

- Those with limited English proficiency (LEP) or reading skills
- Those with diverse cultural and ethnic backgrounds
- Those experiencing homelessness
- Individuals with physical and mental disabilities
- Individuals who identify as gay, lesbian, bisexual, transgender or gender nonconforming

Providers are required to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, Aetna Better Health of California makes its telephonic and face to face language interpretation service available to providers to facilitate member interactions. These services are free to the member and to the provider. However, if the provider chooses to use another resource

for interpretation services, the provider is financially responsible to associated costs.

Our language interpreter vendor provides interpreter services at no cost to providers and members.

Language interpretation services are available for use in the following scenarios:

- If a member requests interpretation services, Aetna Better Health of California Member Services Representatives will assist the member via a three-way call to communicate in the member's native language.
- Members and providers should contact the Member Services Call Center via phone to request face-to-face interpretive services. Aetna Better Health requires at least 48 hours advance notice of the appointment.
- When providers need interpreter services and cannot access them from their office, they can call Aetna Better Health of California to link with an interpreter.

Aetna Better Health of California provides alternative methods of communication for members who are visually impaired, including large print and other formats. Contact our Member Services Department for alternative formats.

The use of professional interpreters is required for linguistic interpretive services. It is never appropriate to ask family members or friends of members to interpret. Further, we provide member materials in other formats to meet specific member needs. Providers must also deliver information in a manner that is understood by the member.

Aetna Better Health of California offers sign language, face-to-face and over-the-phone interpreter services at no cost to the provider or member. Please contact Aetna Better Health of California at **1-855-772-9076** for more information on how to schedule these services in advance of an appointment.

Individuals with Disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. Regular provider office visits will be conducted by our Provider Services staff to verify that network providers are compliant.

Clinical Guidelines

Aetna Better Health of California has Clinical Guidelines and treatment protocols available for providers to help identify criteria for appropriate and effective use of health care services and consistency in the care provided to members and the general community. These guidelines are not intended to:

- Supplant the duty of a qualified health professional to provide treatment based on the individual needs of the member
- Constitute procedures for or the practice of medicine by the party distributing the guidelines
- Guarantee coverage or payment for the type or level of care proposed or provided

Clinical Guidelines are available on our website at [AetnaBetterHealth.com/California](https://www.aetna.com/betterhealth/california)

Office Administration Changes and Training

Providers are responsible to notify our Provider Services Department on any changes in professional staff at their offices (physicians, physician assistants, or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact our Provider Services Department to schedule staff training.

Credentialing/Re-Credentialing

Aetna Better Health of California uses current NCQA standards and guidelines for the review, credentialing and re-credentialing of providers and uses the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource for all provider types. The Universal Credentialing DataSource was developed by America's leading health plans collaborating through CAQH. The Universal Credentialing DataSource is the leading industry-wide service to address one of providers' most redundant administrative tasks: the credentialing application process.

The Universal Credentialing DataSource Program allows providers to use a standard application and a common database to submit one application, to one source, and update it on a quarterly basis to meet the needs of all of the health plans and hospitals participating in the CAQH effort. Health plans and hospitals designated by the providers obtain the application information directly from the database, eliminating the need to have multiple organizations contacting the provider for the same standard information. Providers update their information on a quarterly basis to verify data is maintained in a constant state of readiness. CAQH gathers and stores detailed data from more than 600,000 providers nationwide. All new providers, (with the exception of hospital-based providers) including providers joining an existing participating practice with Aetna Better Health of California, must complete the credentialing process and be approved by the Credentialing and Performance Committee.

Providers are re-credentialed every three years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses, and DEA certificates are also required.

Aetna Better Health of California will verify during the credentialing and re-credentialing process that a home like environment and community integration exists in facilities they intend to contract with as well as in existing network ALFs.

HCBS waiver members residing in assisted living facilities and other residential care facilities must be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

- Private or semi-private rooms
- Roommate for semi-private rooms
- Locking door to living unit
- Access to telephone and length of use
- Eating schedule
- Participation in facility and community activities

Ability to have:

- Unlimited visitation
- Snacks as desired

Ability to:

- Prepare snacks as desired
- Maintain personal sleeping schedule

Licensure and Accreditation

Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as indicated.

Discrimination Laws

Providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84

- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- The Americans With Disabilities Act
- Federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law
- The False Claims Act (31 U.S.C. §§ 3729 et. seq.)
- The Anti-Kickback Statute (section 1128B(b) of the Social Security Act)
- HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164

In addition, our network providers must comply with all applicable laws, rules and regulations, and, as provided in applicable laws, rules and regulations, network providers are prohibited from discriminating against any member based on health status.

Financial Liability for Payment for Services

In no event should a provider bill a member (or a person acting on behalf of a member) for payment of fees that are the legal obligation of Aetna Better Health of California. However, a network provider may collect monies from members in accordance with the terms of the member's Handbook (if applicable). Providers must make certain that they are:

- Agreeing not to hold members liable for payment of any fees that are the legal obligation of Aetna Better Health of California and must indemnify the member for payment of any fees that are the legal obligation of Aetna Better Health of California for services furnished by providers that have been authorized by Aetna to service such members, as long as the member follows Aetna's rules for accessing services described in the approved Member Handbook.
- Agreeing not to bill a member for medically necessary services covered under the plan and to always notify members prior to rendering services.
- Agreeing to clearly advise a member, prior to furnishing a non-covered service, of the member's responsibility to pay the full cost of the services
- Agreeing that when referring a member to another provider for a non-covered service to verify that the member is aware of his or her obligation to pay in full for such non-covered services.

Continuity of Care

Providers terminating their contracts are required to provide a notice before terminating with Aetna Better Health of California. Providers must also continue to treat our members until the treatment course has been completed or care is transitioned. An authorization may be necessary for these services. Members who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost.

Aetna Better Health of California is not responsible for payment of services rendered to members who are not eligible. You may contact our Utilization Management Department for assistance.

Continuity of Care for Pregnant Women

Members should be held harmless by the provider for the costs of medically necessary core benefits and services.

State regulations allow **certain beneficiaries to request a medical exemption** from a managed care plan for up to 12 months to complete a treatment with their current Medi-Cal FFS Provider. This treatment must be for a complex medical condition and must be provided by a physician, certified nurse midwife or licensed midwife who is participating in FFS Medi-Cal and is not contracted with any of the managed care plans available in an eligible beneficiary's county of Residence. (APL 17-007)

In the event a female member entering Aetna Better Health of California is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before Aetna Better Health of California enrollment, Aetna Better Health of California will be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of prior approval and without regard to whether such services are being provided by a contract or non-

contract provider until such time as Aetna Better Health of California can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.

In the event a member entering the health plan is in her second or third trimester of pregnancy and is receiving medically-necessary covered prenatal care services the day before enrollment, Aetna Better Health will be responsible for providing continued access to the prenatal care provider (whether contract or noncontract provider) for sixty (60) days post-partum, provided the member is still eligible for Medicaid, or referral to a safety net provider if the member's eligibility terminates before the end of the post-partum period.

To ensure that the continuity of care and coordination of care requirements are met, Aetna Better Health of California will contact new members to ask if there are any upcoming health care appointments or treatments scheduled and assist members, if they choose to do so, in initiating the continuity of care process. Contact to members may be by telephone, letter or other resources, but shall take place no later than 15 days after enrollment. Aetna Better Health of California will offer up to 12 months of continuity of care with an out-of network provider, in accordance with APL 18-008, if requested by a member. Additionally, Aetna Better Health of California will identify members with higher risk and more complex health care needs at that time (within 44 days of enrollment).

Continuity for Behavioral Health Care

The PCP will provide basic behavioral health services and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.

Provider Marketing

All health care providers delivering services to Aetna Better Health of California members enrolled in Medi-Cal are welcome to inform their patients of the Medi-Cal Plan they have chosen to participate with, but Medi-Cal has strict prohibitions against patient steering, which all providers must observe. The requirements below must be strictly observed by all Medi-Cal providers.

- Providers may inform their patients of all Medi-Cal Plans in which they participate, and can inform patients of the benefits, services, and specialty care services offered through the Medi-Cal Plan in which they participate.
- **Providers are not allowed to disclose only some of the Medi-Cal Plans in which they participate.** Disclosure of Medi-Cal Plan participation must be all or nothing.
- Providers can display signage, provided by the Medi-Cal Plan, at their location indicating which Medi-Cal Plans are accepted there, but must include all Medi-Cal Plans in which they participate in this signage.
- If a provider participates in only one Medi-Cal Plan, the provider can display signage for only one and can tell a patient that is the only Medi-Cal Plan accepted by that provider.
- Providers **MAY NOT RECOMMEND** one Medi-Cal Plan over another Medi-Cal Plan and **MAY NOT OFFER** patients' incentives for selecting one Medi-Cal Plan over another.
- Providers **MAY NOT ASSIST** a patient in the selection of a specific Medi-Cal Plan. Additionally, patients may not use the provider's fax machine, office phone, computer, etc., to make such a selection, except as required for the completion of a Medicaid application as a function of being an enrolled Medicaid Application Center.
- Patients who need assistance with their Health Plan services should call the Member Services Hotline for the Plan in which they are enrolled, and those who wish to learn more about the different Medi-Cal Plans should contact their local county Medi-Cal office to receive assistance in making a Medi-Cal Plan decision.
- Under **NO CIRCUMSTANCES** is a provider allowed to change a member's Medi-Cal Plan for him/her or request a Medi-Cal Plan reassignment on a member's behalf. **Members who wish to change their Medi-Cal Plan for cause must make this request to Medicaid themselves through the respective Medi-Cal County office.**

These prohibitions against patient steering apply to participation in the Medi-Cal programs.

If a provider or Health Plan is found to have engaged in-patient steering, they may be subject to sanctions such as, but not limited to monetary penalties, loss of linked patients and excluded from enrollment in Medicaid/Medi-Cal network opportunities.

CHAPTER 5: COVERED AND NON-COVERED SERVICES

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Services covered by Aetna Better Health of California are listed below. Some limitations and prior authorization requirements may apply.

All services must be medically necessary. If you have questions about covered services, call Member Services at **1-855-772-9076 (TTY: 711)**.

Covered Services

Outpatient (Ambulatory) Services

- Physician services
- Pharmacist services
- Hospital outpatient & outpatient clinic services
- Outpatient surgery (Includes anesthesiologist services.)
- Podiatry
- Chiropractic
- Allergy care
- Treatment therapies (physician administered drugs, chemotherapy, radiation therapy, etc.)
- Dialysis/hemodialysis

Emergency Services

- Emergency room services
- All inpatient and outpatient services that are necessary for the treatment of an emergency medical condition, including dental services, as certified by the attending physician or other appropriate provider.
- Ambulance services

Hospitalization

- Inpatient hospital services
- Anesthesiologist services
- Surgical services (bariatric, reconstructive surgery, etc.)
- Organ & tissue transplantation (kidney transplant, liver transplant, etc.)

Maternity and Newborn Care

- Prenatal care
 - Including services at Freestanding Birth Centers
- Delivery and postpartum care
 - Including services at Freestanding Birth Centers
- Breastfeeding education
- Nurse midwife services, including services at Freestanding Birth Centers
- Abortion is a covered benefit regardless of the gestational age of the fetus.
 - Medical justification and authorization is not required

Mental health and Substance Use Disorder (SUD) Services, including Behavioral Health Treatment

- Outpatient mental health services
- Outpatient substance use disorder services
 - Residential treatment services
- Voluntary inpatient detoxification

Programs such as physical and occupational therapy (known as Rehabilitative & Habilitative Services) and devices

- Physical therapy
- Speech therapy
- Occupational therapy
- Acupuncture
- Cardiac rehabilitation
- Pulmonary rehabilitation
- Skilled nursing facility services (90 days)
- Medical supplies, equipment and appliances (including implanted hearing devices)
- Durable medical equipment
- Orthotics/prostheses
- Hearing aids
- Home health services

Laboratory Services

- Outpatient laboratory and X-ray services
 - Various advanced imaging procedures are covered based on medical necessity.

Preventive and Wellness Services and Chronic Disease Management

- United States Preventive Services Task Force A & B recommended preventive services
- Advisory Committee for Immunization Practices recommended vaccines
- Health Resources and Service Administration's Bright Futures recommendations
- Preventive services for women recommended by the Institute of Medicine
- Family planning services
- Smoking cessation services

Pediatric Services Including Oral and Vision Care

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. EPSDT provides periodic screenings to determine health care needs and, in addition to the standard Medi-Cal benefits, a beneficiary under the age of 21 may receive extended services as medically necessary.

Vision

- Routine eye exam once in 24 months
- Eyeglasses for eligible individuals under the age of 21 and pregnant women through postpartum

Non-Emergency Medical Transportation Services (NEMT)

Ambulance, litter van, or wheelchair van only when ordinary public or private conveyance is medically contra indicated and transportation is required for obtaining needed medical care for a Medi-Cal benefit.

Non-Medical Transportation Services (NMT)

Effective 7/1/17, Aetna Better Health of California must provide NMT when provided as an EPSDT service when members obtain medically necessary covered services. Aetna will make the best effort to refer for and coordinate NMT when services are not covered. Effective 10/1/17, Aetna must provide NMT for all Medi-Cal services, including those not covered by ABHCA's contract with the DHCS. Services that are not covered include, but are not limited to specialty mental health, substance use disorder, dental, and other benefits delivered through the Medi-Cal FFS delivery system according to APL 17-010.

Long Term Services and Supports

- Skilled Nursing Facility services (91+ days)
- Personal Care Services

- Self-Directed Personal Assistance Services
- Community First Choice Option
- Home and Community Based Services
- Community Based Adult Services (CBAS)
- Private duty nursing case management services for members under the age of 21

Adult vision benefits

Members do not need a referral to see an in-network vision provider. Members can find a vision provider in the provider directory online at AetnaBetterHealth.com/California.

Aetna Better Health of California uses VSP for vision services. Members can call VSP at **1-800-877-7195 (TTY: 711)**, Monday – Friday from 8 AM to 5 PM (Central).

Nurse line

Access to a nurse is available 24-hours a day, 7 days a week at **1-855-772-9076 (TTY: 711)**.

Care4Life diabetes coaching program - personalized text messages with appointment and medication reminders, exercise, and weight goal setting and tracking, education, and personal care manager support
www.care4life.com/

Help to stop smoking - smoking cessation medications for up to six months and health coaching
www.nobutts.org/

Nurses, social workers, and community health workers to help members manage their health and get access to the care they need. - www.chhs.ca.gov/Pages/Home.aspx

Medicaid Covered Services

Some services are covered by Medicaid but not by Aetna Better Health of California. Since these services are not covered by our Plan, you do not have to use our network providers to obtain these services.

Service	How to access
Outpatient prescription drugs	Covered Medi-Cal Rx at 1-800-977-2273
Children’s dental services	Covered by state of California
ICF/DD Services	Contact the Office for Citizens with Developmental Disabilities at 1-866-783-5553
All Home & Community-Based Waiver Services	Contact the Office for Citizens with Developmental Disabilities at 1-866-783-5553
Targeted Case Management Services	Contact the Office for Citizens with Developmental Disabilities at 1-866-783-5553
Individualized Education Plan (IEP) services provided by a school district	Contact the California Department of Education at 916-319-0800

Cost for Services

Aetna Better Health of California has a contract with Medi-Cal to provide health care services with no cost sharing. This means members should not be asked to pay a copay when they receive medical services.

Non-Covered Services

There are some services that Aetna Better Health of California does not cover, these include:

- Services or items used only for cosmetic purposes

- Treatment for infertility
- Experimental/investigational procedures drugs and equipment (Phase I & II Clinical Trials are considered experimental)

Women, Infants, and Children Supplemental Nutrition Program (WIC)

WIC services are not covered under ABHCA's contract with the DHCS. However, ABHCA can assist in identifying and referring eligible members. As a part of the referral process, ABHCA will provide the WIC program with a current hemoglobin or hematocrit laboratory result. Provider must document the laboratory result and the referral in the member's medical record as a part of the member's IHA, or as a part of the initial evaluation of pregnant members, and refer and document the referral of pregnant, breastfeeding, or postpartum members or a parent and/or guardian of children under the age of 5 as mandated by 42 CFR 431.635.

Post-Stabilization Services

Aetna Better Health of California covers post-stabilization services provided by a contracted or non-contracted provider in any of the following situations:

- When Aetna Better Health of California authorized the services
- Such services were administered to maintain the member has stabilized condition within thirty (30) minutes after a request to Aetna Better Health of California for authorization of further post-stabilization services.
- When Aetna Better Health of California does not respond to a request to authorize further post-stabilization services within thirty (30) minutes, could not be contacted, or cannot reach an agreement with the treating provider concerning the member's care and a contracted provider is unavailable for a consultation. In this situation, the treating provider may continue the member's care until a contracted provider either concurs with the treating provider's plan of care or assumes responsibility for the member's care.

Medical Necessity

Medical necessity is defined as a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with Aetna Better Health of California's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

You can view a current list of the services that require authorization on our website at **[AetnaBetterHealth.com/California](https://www.aetna.com/betterhealth/california)**. If you are not already registered for the secure web portal, download an application from the California Providers section of the site. If you have questions or would like to get training on the secure provider web portal and the Prior Authorization Requirement Search Tool, please contact our Provider Services Department at **1-855-772-9076**.

Emergency Services

Aetna Better Health of California covers emergency services without requiring prior authorization for members, whether the emergency services are provided by a contracted or non-contracted provider. Aetna Better Health of California will cover emergency services provided outside of the contracting area except in the following circumstances:

- When care is required because of circumstances that could reasonably have been foreseen prior to the members departure from the contracting area
- When routine delivery, at term, if member is outside the contracting area against medical advice, unless the member is outside of the contracting area due to circumstances beyond her control. Unexpected hospitalizations due to complications of pregnancy are covered.

Aetna Better Health of California will abide by the determination of the physician regarding whether a member is sufficiently stabilized for discharge or transfer to another facility.

Pharmacy Services

You can find a more comprehensive description of covered services in Chapter 19.

Telehealth Services

Telehealth services are provided at no cost to members or providers. Providers must be licensed (or equivalent) and be enrolled in FFS Medicaid (if there is a path of enrollment) and will be reimbursed at the same rate as a standard office visit if the service is the same, regardless of modality of delivery. In order to offer Telehealth services, providers must comply with the following:

- Maintain documentation of either verbal or written consent for the use of telehealth from the patient
- Comply with all state and federal laws regarding the confidentiality of health care information
- Patient's rights to own medical information applies to telehealth interactions
- The patient is not precluded from receiving in-person healthcare services after agreeing to receive telehealth services

Certain types of services cannot be appropriately delivered via telehealth. Providers must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service.

CHAPTER 6: BEHAVIORAL HEALTH

Mental Health/Substance Use Services

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Behavioral health is defined as those services provided for the assessment and treatment of problems related to mental health and substance use disorders. Substance use disorders include abuse of alcohol and other drugs. In order to meet the behavioral health needs of our members, Members can receive inpatient behavioral health services under the Medicaid Fee-for-Service (FFS) program for behavioral health services, a local county health department office.

Aetna Better Health of California's Integrated Care Management Program ICM Objective:

- An integrated approach to physical and behavioral health conditions, that also addresses bio-psychosocial circumstances, is critical to help our most vulnerable and highest risk members. Team with the member and care providers to enhance care outcomes. Work as an interdisciplinary team that combines core competencies in physical and behavioral health within a systems framework to manage bio-psycho-social complexity and challenging relationships with members and their families.
- Focuses on member health and well-being using behavioral change strategies, relationship building and engaging community and social systems to wrap around the member, to enhance resiliency and self-efficacy.
- Starts with assessing members as they are identified, evaluating them as "whole" beings, and includes all elements surrounding them that may impact their health status.
- Assigns to an appropriate level of intervention intensity, and staff will team with them in managing their care.
- Tools and services assist in decreasing the need for invasive care and increasing self-management to improve health and well-being.
- Establish a collaborative working relationship with providers in each county.
- Identify strengths: Assure we neither duplicate nor disrupt what is working well.
- Identify and prioritize gaps in the local array of services and support each member's needs and conditions in general and priority populations in particular.
- Identify and respond to opportunities for training and technical assistance to support providers.

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 of California providers are expected to:

- Screen, evaluate, treat and refer (as medically appropriate), any behavioral health problem/disorder.
- Treat mental health and substance use disorders within the scope of their practice and make appropriate referrals.
- Inform Members how and where to obtain behavioral health services.

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 referred for physical health, behavioral health or substance use disorder, dual or multiple diagnoses or developmental disabilities. With the member's permission, our case management staff can facilitate coordination of case management related substance use screening, evaluation, and treatment.

Members seen in the primary care setting may present with a behavioral health condition, which the PCP must be prepared to recognize. Primary Care Providers (PCPs) are encouraged to use behavioral health screening tools, conduct an Individual Health Education Behavioral Assessment (IHEBA), 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 PCP 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. Mental Health/Substance use (MH/SUD) providers are asked to communicate any concerns regarding the member's medical condition to the PCP, with the members consent if required, and work collaboratively on a plan of care.

Information is shared between Aetna Better Health of California, behavioral health and medical providers to verify 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 within 24 hours of receipt of results in urgent or emergency cases, and notification within 10 business days of receipts of results for non-urgent or non-emergency lab results.

Behavioral Health Coverage for Members Under 21 Years of Age

In accordance with Federal Early and Periodic Screening, Diagnostic and Treatment requirements, Aetna Better Health of California will provide coverage for all medically necessary behavioral health services for members under 21 years of age. This applies to children diagnosed with autism spectrum disorder and children for whom a licensed physician, surgeon or psychologist determines that behavioral health services are medically necessary. There are no treatment limitations for behavioral health services for members under 21 years of age.

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 in Chapter 4 of this Manual.

Mental Health Parity and Addiction Equality Act (MHPAEA)

The Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted to verify "parity" or fairness between mental health and substance use disorder (MH/SUD) benefits and medical/surgical benefits covered by a Managed Care Organization (MCO) such as Aetna Better Health of California. Enacted in 2008, MHPAEA does not require an (MCO) to offer MH/SUD benefits, but if the plan does so, it must offer the benefits on par with the other medical/surgical benefits it covers. In 2010, The Departments of Treasury, Labor, and Health and Human Services issued Interim Final Regulations (IFR) implementing the law. On Friday November 8, 2013, the Departments issued a Final Rule (FR) implementing the law.

A simple example of a parity requirement would be the frequency of office visits. Under MHPAEA, a plan may not allow a patient to have an unlimited number of medically necessary appointments with a dermatologist, but limit patients to only 5 appointments with a psychiatrist. However, while the premise of the law seems simple; the regulations related to the law are quite complicated, and therefore, implementation of the law has been complicated. This brief summary of the law is intended to help providers understand the law and the rights it affords them.

Links to Key Materials

- Final regulation, available at www.dol.gov/ebsa/pdf/mhpaeafinalrule.pdf
- Interim Final Regulation, available at www.dol.gov/ebsa/mentalhealthparity/
- FAQs about ACA Implementation Part XVII and Mental Health Parity Implementation, available at www.dol.gov/ebsa/faqs/faq-aca17.html
- U.S. Department of Health and Human Services' Study: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, available at www.dol.gov/ebsa/pdf/hhswellstonedomenicimhpaealargeemployerandghpbconsistency.pdf
- News release, available at www.dol.gov/ebsa/newsroom/2013/13-2158-NAT.html
- CMS January 16, 2013 letter to State Health Officials and Medicaid Directors, available at www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf
- CMS overview document www.cms.gov/regulations-and-guidance/health-insurance-reform/healthinsreformforconsume/downloads/mhpaea.pdf

CHAPTER 7: MEMBER RIGHTS AND RESPONSIBILITIES

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Aetna Better Health of California is committed to treating members with respect and dignity. Member rights and responsibilities are shared with staff, providers, and members each year through our web site, secure web portal, and provider/practitioner newsletter.

Treating a member with respect and dignity is good business for the provider's office and often can improve health outcomes. Your contract with Aetna Better Health of California requires compliance with member rights and responsibilities, especially treating members with respect and dignity. Understanding member' rights and responsibilities are important because you can help members to better understand their role in and improve their compliance with treatment plans.

It is Aetna Better Health of California's 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 below. Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity.

In the event that Aetna Better Health of California is made aware of an issue with a member not receiving the rights as identified above, Aetna Better Health of California will initiate an investigation into the matter and further peer review action may be necessary.

In the event Aetna Better Health of California is made aware of an issue when the member is not demonstrating the responsibilities as outlined above, Aetna Better Health of California will make good faith efforts to address the issue with the member and educate the member on their responsibilities.

Member Rights

Members, their families, and guardians have the right to information related Aetna Better Health of California, its services, its providers and member rights and responsibilities in a language they can understand.

Members have the following rights:

- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan and its services, including covered services, practitioners, and member rights and responsibilities.
- To receive fully translated written member information in your preferred language, including all grievance and appeals notices.
- To make recommendations about Aetna Better Health of California's member rights and responsibilities policy.
- To be able to choose a primary care provider within Aetna Better Health of California's network. □ To have timely access to network providers.
- To participate in decision making with providers regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care you got.
- To know the medical reason for Aetna Better Health of California's decision to deny, delay, terminate or change a request for medical care.
- To get care coordination
- To ask for an appeal of decisions to deny, defer or limit services or benefits.
- To get no-cost interpreting services for your language.
- To get free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with Aetna Better Health of California and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible.

- To disenroll from Aetna Better Health of California and change to another health plan in the county upon request.
- To access minor consent services.
- To get no-cost written member information in other formats (such as braille, large-size print, audio and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by Aetna Better Health of California, your providers or the State.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services and emergency services outside Aetna Better Health of California's network pursuant to the federal law.

Member Responsibilities

Aetna Better Health of California encourages members to be responsible for their own health care by becoming informed and active participants in their care. Aetna Better Health of California members, their families, or guardians are responsible for:

- Read this Evidence of Coverage. It tells you about our services, and how to file a grievance or appeal.
- Follow Aetna Better Health rules.
- Use your ID cards when you go to health care appointments or get services and do not let anyone else use your cards.
- Treat the doctors, staff and people providing services to you with respect.
- Know the name of your PCP and your care manager if you have one.
- Know about your health care and the rules for getting care.
- Tell the Plan and DHCS when you make changes to your address, telephone number, family size, moving out of state, employment change and other information that might affect enrollment.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Be respectful to the health care providers who are giving you care.
- Schedule your appointments, be on time, and call if you are going to be late or miss your appointment. If you need to cancel an appointment, it must be done at least twenty-four (24) hours before your scheduled visit.
- Use the emergency room for true emergencies only.
- Give all information about your health to Aetna Better Health and your doctor. This includes immunization records for members under age twenty-one (21).
- Tell your doctor if you do not understand what they tell you about your health so that you and your doctor can make plans together about your care.
- Tell the Plan and DHCS about your concerns, questions or problems.
- Ask for more information if you do not understand your care or health condition.
- Follow what you and your doctor agree to do. Make follow-up appointments. Take medicines and follow your doctor's care instructions.
- Schedule wellness check-ups. Members under twenty-one (21) years of age need to follow the Early Periodic Screening Diagnosis and Treatment (EPSDT) schedule.
- Get care as soon as you know you are pregnant. Keep all prenatal appointments.
- Tell us about any other insurance you have Tell us if you are applying for or get any other health care benefits.
- Bring shot records to all appointments for children under 18 years old.
- Give your doctor a copy of your living will or advance directive.
- Keep track of the cost-sharing amounts you pay.

For questions or concerns, please contact our Provider Services Department at **1-855-772-9076**.

Member Rights Under Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to organizations that receive financial assistance from any federal department or agency, including hospitals, nursing homes, mental health centers, and human service programs.

Section 504 prohibits organizations from excluding or denying individuals with disabilities an equal opportunity to receive benefits and services. Qualified individuals with disabilities have the right to participate in, and have access to, program benefits and services.

Under this law, individuals with disabilities are defined as persons with a physical or mental impairment that substantially limits one or more major life activities. People who have a history of physical or mental impairment, or who are regarded as having a physical or mental impairment that substantially limits one or more major life activities, are also covered. Major life activities include caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning. Some examples of impairments that may substantially limit major life activities, even with the help of medication or aids/devices, are: Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness.

In addition to meeting the above definition, for purposes of receiving services, qualified individuals with disabilities are persons who meet normal and essential eligibility requirements.

Providers treating members may not, based on disability:

- Deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits
- Deny access to programs, services, benefits or opportunities to participate as a result of physical barriers

CHAPTER 8: EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

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The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

The EPSDT Program consists of two mutually supportive, operational components: **(1) assuring the availability and accessibility of required health care resources; and (2) helping members and their guardians effectively use these resources.** These components enable Medicaid agencies to manage a comprehensive health program of prevention and treatment, to seek out eligible members and inform them of the benefits of prevention and the health services and assistance available and to help them and their families use health resources, including their own talents and knowledge, effectively and efficiently. It also enables them to assess the patient's health needs through initial and periodic examinations and evaluations, and to see that the health problems found are diagnosed and treated early, before they become more complex and their treatment more costly. (Adapted from CMS website at www.cms.gov/MedicaidEarlyPeriodicScrn/).

Periodicity Schedule

The American Academy of Pediatrics publishes periodicity schedules that identify minimum guidelines for EPSDT screenings. You can view updated schedules on their website at http://brightfutures.aap.org/clinical_practice.html.

Identifying Barriers to Care

Understanding barriers to care is essential to helping members receive appropriate care, including regular preventive services. We find that although most members and caregivers understand the importance of preventive care, many confront seemingly insurmountable barriers to readily comply with preventive care guidelines. A recent study by the U.S. Department of Health and Human Services found that fewer than 50 percent of children in the study sample received any documented EPSDT services. To address this, Aetna Better Health of California trains its Member Services and Care Management Staff to identify potential obstacles to care during communications with members, their family/caregivers, Primary Care Providers (PCPs) and other relevant entities and works to maintain access to services.

Examples of barriers to preventive care that we have encountered include:

- Cultural or linguistic issues
- Lack of perceived need if the member is not sick
- Lack of understanding of the benefits of preventive services
- Competing health-related issues or other family/work priorities
- Lack of transportation
- Scheduling difficulties and other access issues

We work with providers to routinely link members with services designed to enhance access to preventive services, including:

- Facilitating interpreter services
- Locating a provider who speaks a particular language
- Arranging transportation to medical appointments
- Linking members with other needed community-based support services

Aetna Better Health of California closely monitors EPSDT metrics throughout the year to identify trends and potential opportunities for improvement. Aetna Better Health of California also notifies members annually of their eligibility for EPSDT services and encourages the use of the services.

Educating Members about EPSDT Services

Aetna Better Health of California informs members about the availability and importance of EPSDT services, including information regarding wellness promotion programs that Aetna Better Health of California offers. The information process includes:

- Member Handbook & Evidence of Coverage
- Member newsletters and bulletins
- Aetna Better Health of California's website
- Educational flyers
- Reminder postcards
- Care plan interventions for high risk members enrolled in care management

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 California's periodicity schedule, including federal and State laws standards and national guidelines (i.e., **[American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care: \[http://brightfutures.aap.org/clinical_practice.html\]\(http://brightfutures.aap.org/clinical_practice.html\)](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).
- Fully document all elements of each EPSDT assessment, including anticipatory guidance and follow-up activities on the state-required standard encounter documentation form and verify that the record is completed and readable.
- Comply with Aetna Better Health of California's Minimum Medical Record Standards for Quality Management, EPSDT Guidelines and other requirements under the law.
- Cooperate with Aetna Better Health of California's periodic reviews of EPSDT services, which will include chart reviews to assess compliance with standards.
- Report members' EPSDT visits by recording the applicable Current Procedural Terminology (CPT) preventive codes on the required claim submission form.
- Contact members or their parents/guardians after a missed EPSDT appointment so that it can be rescheduled.
- Have systems in place to document and track referrals including those resulting from an EPSDT visit. The system should document the date of the referral, date of the appointment and date information is received documenting that the appointment occurred.
- California law requires laboratories and health care providers performing blood lead analysis on blood specimens drawn in California to electronically report all results to CLPPB.

Aetna Better Health of California requires participating providers to make the following recommended and covered services available to EPSDT-eligible children at the ages recommended on the state Medicaid regulators' periodicity schedule:

- Immunizations, education, and screening services, provided at recommended ages in the child's development, including all of the following:
 - Comprehensive health and developmental history (including assessment of both physical and mental health development).
 - Comprehensive unclothed physical exam.
 - Appropriate immunizations (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines).
 - Laboratory tests.

- Health education/anticipatory guidance - Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental exams provide the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.
- Vision services, including periodic screening and treatment for defects in vision, including eyeglasses.
- Dental services, including oral screening, periodic direct referrals for dental examinations (according to the state periodicity schedule), relief of pain and infections, restoration of teeth, and maintenance of dental health. A dental screening/oral health assessment must be performed as part of every periodic assessment, with annual dental referrals made no later than 12 months of age or when referral is indicated based on assessment. Additionally, MCPs must cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists but may require prior authorization for medical services required in support of dental procedures.
- Hearing services, including, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids.
- Lead toxicity screening consists of two components, verbal risk assessment and blood lead testing in accordance with CMS and California state requirements. Other necessary health care to correct or ameliorate physical and mental illnesses and conditions discovered by the screening process.
- Diagnostic services, including referrals for further evaluation whenever such a need is discovered during a screening examination.
- Treatment or other measures to correct or improve defects and physical and mental illnesses or conditions discovered by the screening services.

For questions or concerns, please contact our Provider Services Department at **1-855-772-9076**.

PCP Notification

On at least a quarterly basis Aetna Better Health of California will provide all PCPs with a list of members who have not had an encounter and who have not complied with the EPSDT periodicity and immunization schedules for children.

Direct-Access Immunizations

Member may receive influenza and pneumococcal vaccines from any network provider without a referral, and there is no cost to the member if it is the only service provided at that visit.

Palliative Care

Palliative care consists of patient and family centered care that optimizes quality of life by anticipating, preventing and treating suffering. The provision of palliative care is not based on the member's life expectancy and may be provided concurrently with curative care. A member with a serious illness who is receiving palliative care may choose to transition to hospice care if the member meets the hospice eligibility criteria. A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care. A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.

Eligibility Criteria:

- The member has started to or is likely to use the hospital or emergency department as a means to manage an advanced disease (not including elective procedures)
- The member's death within a year would not be unexpected based on clinical status.
- The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective.
- The member agrees to attempt, as medically/clinically appropriate, in-home or outpatient disease

management/palliative care instead of first going to the emergency department and agrees to participate in advance care planning discussions.

Some of the conditions that may qualify for palliative care for members age 21 years and older are congestive heart failure, chronic obstructive pulmonary disease, advanced cancer, such as stage III or IV solid organ cancer, lymphoma or leukemia, liver disease.

Members under the age of 21 may be eligible for palliative care if the family and/or legal guardian agree to the provision of pediatric palliative care services and there is documentation of a life-threatening diagnosis. This can include, but is not limited to conditions for which curative treatment is possible but may fail such as advanced or progressive cancer or complex and severe heart disease, conditions requiring long-term treatment aimed at maintaining quality of life, such as HIV, cystic fibrosis or muscular dystrophy or progressive conditions for which treatment is exclusively palliative after diagnosis, such as progressive metabolic disorders or severe forms of osteogenesis imperfecta, or conditions involving severe, non-progressive disability or causing extreme vulnerability to health complications such as extreme prematurity, severe neurologic sequelae of infectious disease or trauma or severe cerebral palsy with recurrent infection or difficult to control symptoms.

Palliative care may be provided by Aetna Better Health providers in a variety of settings, including but not limited to, inpatient, outpatient or community-based settings.

CHAPTER 9: MEMBERS WITH SPECIAL NEEDS

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Adults with special needs include our members with complex and chronic medical conditions requiring specialized health care services. This includes persons with disabilities due to physical illnesses or conditions, behavioral health conditions, substance use disorders, and developmental disabilities. Members may be identified as having special needs because they are homeless. Children with special health care needs are those members who have or are at an increased risk for a chronic physical, developmental, behavioral or emotional condition, and who require health and related services of a type or amount beyond that generally required by children.

Aetna Better Health providers are required to refer members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and treatment of non-medical services provided through the Regional Centers. These services consist of services such as but not limited to, respite, out-of-home placement and supportive living. Aetna Better Health will monitor and coordinate all medical services with the Regional Center staff, which includes identification of all appropriate services including medically necessary outpatient mental health services, which may need to be provided to the member.

Screening, Brief Interventions, and Referral to Treatment (SBIRT)

Effective January 1, 2014, the state of California started offering the SBIRT benefit to Medi-Cal beneficiaries. This benefit aligns with the U.S. Preventative Services Task Force recommendation and is offered annually to all Medi-Cal beneficiaries 18 years and older in primary care settings. In accordance with the Bright Futures/American Academy of Pediatrics recommendation, adolescent Medi-Cal beneficiaries, ages 11 -17, are to be given an alcohol and drug use assessment annually in primary care settings using the CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) tool for screening.

As part of SBIRT, Aetna Better Health of California will provide at least one alcohol misuse screening per year, as medically necessary. Aetna Better Health of California will also offer behavioral counseling interventions for alcohol misuse and/or refer any member identified as being engaged in risky or hazardous drinking to mental health and/or alcohol use disorder services as specified in DHCS APL 18-0014. PCPs must maintain documentation of the alcohol misuse screening of their members.

California Children's Services (CCS)

California Children's Services (CCS) is a state program for children with certain diseases or health problems. Through this program, children up to 21 years old can get the health care and services they need. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.

The CCS program is administered as a partnership between county health departments and the California Department of Health Care Services (DHCS). Currently, approximately 70 percent of CCS-eligible children are also Medi-Cal eligible. The Medi-Cal program reimburses their care. The cost of care for the other 30 percent of children is split equally between CCS Only and CCS Healthy Families. The cost of care for CCS Only is funded equally between the State and counties. The cost of care for CCS Healthy Families is funded 65 percent federal Title XXI, 17.5 percent State, and 17.5 percent county funds.

In addition, Insurance Code Sections 12693.62, 12693.64 and 12693.66, relating to the California's Healthy Families Program, provides that the services authorized by the CCS program to treat a Healthy Families plan's subscriber's CCS-eligible medical condition are excluded from the Aetna Better Health's responsibilities. Aetna Better Health's responsibility for providing all covered medically necessary health care and case management services changes at the time that CCS eligibility is determined by the CCS program for the plan

subscriber. Aetna Better Health is still responsible for providing primary care and prevention services not related to the CCS-eligible medical condition to the plan subscriber so long as they are within the Healthy Families program scope of benefits. Aetna Better Health also remains responsible for children referred to but not determined to be eligible for the CCS program.

As an Aetna Better Health provider, it is expected that you understand and follow the items below regarding the CCS program:

- 1) Perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS eligible medical condition.
- 2) Understand that CCS reimburses only CCS paneled providers and CCS-approved hospitals within Aetna Better Health's network and only from the date of referral.
- 3) That Aetna Better Health enables initial referrals of Member's with CCS-eligible conditions to be made to the local CCS program by telephone, same-day mail or fax, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.
- 4) That Aetna Better Health will continue to provide all Medically Necessary Covered Services for the Member's CCS eligible condition until CCS eligibility is confirmed.
- 5) That Aetna Better Health, once eligibility for the CCS program is established for a Member, will continue to provide all Medically Necessary Covered Services that are unrelated to the CCS eligible condition and will monitor and ensure the coordination of services and joint case management between our Primary Care Providers, the CCS specialty providers, and the local CCS program.

Aetna Better Health of California developed methods for:

- Promoting well-child care to children with special needs, who may be cared for by multiple subspecialists
- Health promotion and disease prevention for adults and children identified as having special needs
- Coordination and approval for specialty care when required
- Diagnostic and intervention strategies to address the specific special needs of these members
- Coordination and approval of home therapies and home care services when indicated
- Care management for adults with special needs to address self-care education to reduce long-term complications and to coordinate care so that long-term complications may be treated as necessary
- Care management systems to assure that children with serious, chronic and rare disorders receive appropriate diagnostic work ups on a timely basis
- Access to specialty centers inside and outside of California for diagnosis and treatment of rare disorders

The Initial Health Screen (IHS) the outreach call and Health Risk Questionnaire for new members will assist us in identifying those with special needs. We will also review hospital and pharmacy utilization data. Additionally, we rely on you, our network providers, to complete the Initial Health Assessment (IHA) within 120 days of the members enrollment to identify members who are at risk of or have special needs and those who are at risk for nursing home level of care. Once identified, we will follow-up with a Comprehensive Needs Assessment for each of these members. Additionally, providers must conduct an Individual Health Education Behavioral Assessment (IHEBA) in coordination with the Initial Health Assessment (IHA). This information must be included in the patient's medical records and supplied to Aetna Better Health of California or its delegates upon request.

Aetna Better Health of California has policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member.

Aetna Better Health of California will develop care plans that address the member's service requirements with respect to specialist physician care, durable medical equipment, medical supplies, home health services, social services, transportation, etc. Our care management and utilization management teams collaborate closely so that all required services are furnished on a timely basis. We facilitate communication among providers, whether they are in or out of our network.

Outreach and enrollment staff are trained to work with members with special needs, to be knowledgeable about their care needs and concerns. Our staff uses interpreters when necessary to communicate with members and potential members who prefer not to or are unable to communicate in English and use the CA Relay system and American Sign Language interpreters, if necessary.

If a new member upon enrollment or a member upon diagnosis requires very complex, highly specialized health care services, the member may receive care from a contracted specialist or a contracted specialty care center with expertise in treating the life-threatening disease or specialized condition. The specialist or specialty care center will be responsible for providing and coordinating the member's primary and specialty care. The specialist or specialty care center, acting as both primary and specialty care provider, will be permitted to treat the member without a referral from the member's Primary Care Provider (PCP) and may authorize such referrals, procedures, tests and other medical services. If approval is obtained to receive services from a non-network provider, the care will be provided at no cost to the member. If our network does not have a provider or center with the expertise the member requires, we will authorize care out of network.

After-hours protocol for members with special needs is addressed during initial provider trainings, in our Provider Manual. Providers must be aware that non-urgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs. We expect our contracted providers to have systems for members with special needs to reach a provider outside of regular office hours. Our Aetna Better Health of California Nurse Line is available 24 hours a day 7 days a week for members with an urgent or crisis situation.

Aetna Better Health of California require our contacted providers to use the most current diagnosis and treatment protocols and standards established by the medical community in conjunction with the Department of Health Care Services (DHCS). During initial provider orientations, we will highlight and reinforce the importance of using the most current diagnosis and treatment protocols.

Provider Monitoring

The methods we utilize to monitor our providers and members compliance/success in obtaining the appropriate care associated with EPSDT include a multi-pronged approach to maximize our quality results and care of this specific member population. The methods include, but are not limited to:

1. Analysis and evaluation of provider utilization
 - EPSDT Audit and other provider office visits
 - EPSDT Compliance Report
2. Tracking and trending provider data
 - Evaluation of performance measures and outcome data including Healthcare Effectiveness Data and Information Set (HEDIS[®]) and Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) results (monitoring results on a monthly basis)
 - Tracking Emergency Rooms utilization by members
3. Review and tracking of member grievances and appeals and provider complaints to identify trends
 - Peer review of quality, safety, utilization and risk management referrals
 - Re-credentialing review activities
 - Review of gaps in care reports and analysis of data from PCP profiles and performance reports
 - Review of sentinel events
4. Monitoring network capacity and availability and accessibility to care delivery systems, re-credentialing review activities.

Our Provider Services Department educates providers about EPSDT program requirements and monitors the adequacy of our EPSDT network. Provider Services Staff may take referrals from a provider to have a member outreached by care management staff, especially if the provider has been unable to reach the member to schedule an appointment for EPSDT-related services. Providers Services Staff may also take referrals from providers who identify problems through EPSDT exams.

Identify and Track At-Risk Members

Aetna Better Health of California uses data-driven tools to provide early detection of members who are at risk of becoming high cost, who have actionable gaps or errors in care and who may benefit from Care Management. These tools have two main components. The first is our predictive modeling tool known as the CORE model, or Consolidated Outreach and Risk Evaluation, which uses predictive modeling based on claims data, pharmacy data, and diagnoses along with predictive modeling that indicates each member's risk of ED utilization and inpatient admission over the next twelve (12) months. We supplement this information with data collected from Health Risk Assessments. We track member information in a web-based care management tracking application.

These tools, described below, enable us to work closely with providers, members and their families or caregivers to help improve clinical outcomes and enhance the quality of members' lives.

Predictive Modeling

Aetna Better Health of California's predictive modeling software identifies and stratifies members who are eligible for our care management programs. It sorts, analyzes, and interprets historical claims, pharmacy, clinical and demographic data to identify gaps in care and to make predictions about future health risks for each member. The application funnels information from these various sources into a member profile that allows our Case Managers to access a concise twelve (12) month summary of activity. This data then links to our customized care management tracking application.

Once analyzed, our predictive modeling software ranks members and prepares a monthly "target" report of the members most likely to benefit from care management services. In addition to the scoring methodology, predictive modeling also looks at certain "triggers" to alert Case Managers to potential risk factors, including:

- Members with new hospital authorizations (currently inpatient) or authorizations for certain scheduled services (i.e. home health or selected surgical procedures)
- Calls received by Aetna Better Health of California's Member Services Department

Health Risk Questionnaire (HRQ)

Aetna Better Health of California also assesses members through the Health Risk Questionnaire (HRQ). Aetna Better Health of California staff members go over the HRQ with the member or caregiver during a telephone call made to each member to welcome them to the health plan. The HRQ gathers:

- Member contact information
- Primary Care Provider (PCP) or medical home information
- Member's health history and self-rated assessment of health
- Frequency of ER use
- Medication usage

Case Management (CM) Business Application Systems

Our care management business application system stores and retrieves member data, claims data, pharmacy data, and history of member interventions and collaboration. It houses a comprehensive assessment, condition-specific questionnaires and care plans and allows care management staff to set tasks and reminders to complete actions specific to each member. It provides a forum for clear and concise documentation of communication with providers, members, and caregivers. It retains history of events for use of the information in future cases. The system interfaces with our predictive modeling software, the inpatient census tool and allows documents to be linked to the case. It also provides multiple queries and reports that measure anything from staff productivity and staff interventions to coordination and collaboration and outcomes in care management.

Medical Necessity

Medical necessity is defined as a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the provider and in accordance with Aetna Better Health of California's guidelines for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

Any such services must be clinically appropriate, individualized, specific, and consistent with the symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-Demonstration approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary".

Determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or on an exception basis, must be documented in writing. The determination is based on medical information provided by the member, the member's family/caregiver and the PCP, as well as any other providers, programs, agencies that have evaluated the member. Medical necessity determinations must be made by qualified and trained health care providers.

Referrals to Care Management

In addition to the tools and referrals to Care Management identified above, providers can refer members to Care Management directly, by filling and sending the following form securely to [**AetnaBetterHealthCACM@aetna.com**](mailto:AetnaBetterHealthCACM@aetna.com).



ABHCA CM Referral
Form.doc

CHAPTER 11: CONCURRENT REVIEW

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Concurrent Review Overview

Aetna Better Health of California conducts concurrent utilization review on each member admitted to an inpatient facility, including skilled nursing facilities and freestanding specialty hospitals. In compliance with Health and Safety Code 1367.01(C): A health care service plan subject to this section, except a plan that meets the requirements of Section 1351.2, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the MCG Guidelines. Admission certification is conducted within one business day of receiving notification.

Continued stay reviews are conducted before the expiration of the assigned length of stay. Providers will be notified of approval or denial of length of stay. Our nurses conduct these reviews. The nurses work with the medical directors in reviewing medical record documentation for hospitalized members.

MCG formerly (Milliman Care Guidelines)

Aetna Better Health of California uses MCG guidelines to verify consistency in hospital-based utilization practices. The guidelines span the continuum of member care and describe best practices for treating common conditions. MCG guidelines are updated regularly as each new version is published. A copy of individual guidelines pertaining to a specific case is available for review upon request.

Discharge Planning Coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the member and for involving the member and family in implementing the plan.

Our Concurrent Review Nurse (CRN) works with the hospital discharge team and attending physicians to verify that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning
- Facilitating or attending discharge planning meetings for members with complex and multiple discharge needs.
- Providing hospital staff and attending physician with names of network providers (i.e., home health agencies, Durable Medical Equipment (DME)/medical supply companies, other outpatient providers).
- Informing hospital staff and attending physician of covered benefits as indicated.

Discharge from a Skilled Nursing Facility

All discharges from a Skilled Nursing Facility (SNF) must be coordinated with the member's Case Manager. In accordance with Section 83 of Title 42 of the code of Federal Regulations, resident rights, any discharge or transfer of a member must be based on a medical reason, for his or her welfare, for the welfare of other patients, or for nonpayment (except as prohibited by Medicare (Title XVIII) or Medicaid (XIX) of the Social Security Act). Regardless of reason, the member, his or her representative, and the member's Case Manager must be involved in discharge planning.

CHAPTER 12: PRIOR AUTHORIZATION

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Primary care providers (PCP) or treating providers are responsible for initiating and coordinating a members request for authorization. However, specialists, PCPs and other providers may need to contact the Prior Authorization Department directly to obtain or confirm a prior authorization.

The requesting provider is responsible for complying with Aetna Better Health of California's prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health of California will not prohibit or otherwise restrict providers, acting within the lawful scope of their practice, from advising, or advocating on behalf of, an individual who is a patient and member of Aetna Better Health of California about the patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Emergency Services

Emergency medical services are permitted to be delivered in or out of network without obtaining prior authorization if the member was admitted for the treatment of an emergency medical condition. Aetna Better Health of California will not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

Payment will not be withheld from providers in or out of network. However, notification is encouraged for appropriate coordination of care and discharge planning. The notification will be documented by the Prior Authorization Department or concurrent review clinician. Additionally, emergency medical services include at least a 72-hour supply of medically necessary discharge drugs when needed.

Post-stabilization Services

Aetna Better Health of California will cover post-stabilization services under the following circumstances without prior authorization, whether or not the services are provided by an Aetna Better Health of California network provider:

- The provider requested prior approval for the post-stabilization services, but Aetna Better Health of California did not respond within thirty (30) minutes of the request
- The provider could not reach Aetna Better Health of California to request prior approval for the services
- The Aetna Better Health of California representative and the treating provider could not reach an agreement concerning the member's care, and an Aetna Better Health of California medical director was not available for consultation
 - Note: In such cases, the treating provider will be allowed an opportunity to consult with an Aetna Better Health of California medical director; therefore, the treating provider may continue with the member's care until a medical director is reached or any of the following criteria are met;
 - An Aetna Better Health of California provider with privileges at the treating hospital assumes responsibility for the member's care.
 - An Aetna Better Health of California provider assumes responsibility for the member's care through transfer.
 - Aetna Better Health of California and the treating provider reach an agreement concerning the member's care.
 - The member is discharged.

Services Requiring Prior Authorization

Our Secure Web Portal located on our website, lists the services that require prior authorization, consistent with Aetna Better Health of California's policies and governing regulations. The list is updated at least annually and updated

periodically as appropriate. In addition to the list, you will find a link that will allow you to access ProPat, which is an easy tool in which you enter codes to see if a Prior Authorization is needed or not. For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website.

Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment. All out of network services must be authorized.

Exceptions to Prior Authorizations

- Access to family planning services
- Well-woman services by an in-network provider
- Minor Consent Services
- Basic Prenatal Care
- Preventive Services
- STD and HIV testing and services

Provider Requirements

Generally, a member's PCP, or treating provider is responsible for initiating and coordinating a request for authorization. However, specialists and other providers may need to contact the Prior Authorization Department directly to obtain or confirm a prior authorization.

The requesting provider is responsible for complying with Aetna Better Health of California's prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims.

A prior authorization request must include the following:

- Current, applicable codes may include:
 - Current Procedural Terminology (CPT)
 - International Classification of Diseases, 10th Edition (ICD-10)
 - Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes
 - National Drug Code (NDC)
- Name, date of birth, sex, and identification number of the member
- Primary care provider or treating provider
- Name, address, phone and fax number and signature, if applicable, of the referring or provider
- Name, address, phone and fax number of the consulting provider
- Problem/diagnosis, including the ICD-10 code
- Reason for the referral
- Presentation of supporting objective clinical information, such as clinical notes, laboratory and imaging studies, and treatment dates, as applicable for the request

All clinical information must be submitted with the original request.

We will take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe. Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, will not be entitled to payment for the provision of such item or service. Should a provider fail or refuse to respond to our request for medical record information, it is our discretion and directive by DHCS, we will, at a minimum, impose financial penalties against the provider as appropriate.

How to request Prior Authorizations

A prior authorization request may be submitted by:

- Submitting the request through the 24/7 Secure Provider Web Portal located on the Aetna Better

Health of California's website at [AetnaBetterHealth.com/California](https://www.aetna.com/better-health/california).

- Fax the request form to **1-844-584-4450** for San Diego and **1-866-489-7441** for Sacramento (form is available on our website). Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing.
- Through our toll-free number at **1-855-772-9076**.
- If you are contracted with an IPA, please contact the IPA that the member is assigned to.

To check the status of a prior authorization you submitted or to confirm that we received the request, please visit the Provider Secure Web Portal at [AetnaBetterHealth.com/California](https://www.aetna.com/better-health/california), or call us at **1-855-772-9076**. The portal will allow you to check status, view history, and email a Case Manager for further clarification if needed.

For further information about the Secure Web Portal, please review [Chapter 4](#) of this manual. If a response for non-emergency prior authorization is not received within 15 days, please contact us at **1-855-772-9076**.

Treating Provider Becomes Unavailable

Aetna Better Health will ensure that at least ten (10) days of advanced notice is given to a member when a Notice of Action results in a termination, suspension, or reduction of previously authorized services. Aetna Better Health will shorten the advanced notice to five (5) days if probable recipient fraud has been verified.

Medical Necessity Criteria

To support prior authorization decisions, Aetna Better Health of California uses nationally recognized, and community developed, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Prior authorization staff members that make medical necessity determinations are trained on the criteria and the criteria is established and reviewed according to Aetna Better Health of California policies and procedures.

Clinical medical necessity determinations are based only on the appropriateness of care and service and the existence of coverage. Aetna Better Health of California does not specifically reward practitioners or other individuals for issuing denials of coverage or care; or provide financial incentives of any kind to individuals to encourage decisions that result in underutilization.

For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health of California uses the following medical review criteria. Criteria sets are reviewed annually for appropriateness to the Aetna Better Health of California's population needs and updated as applicable when nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate providers in developing, adopting, or reviewing criteria. The criteria are consistently applied, consider the needs of the members, and allow for consultations with requesting providers when appropriate. Providers may obtain a copy of the utilization criteria upon request by contacting an Aetna Better Health of California provider relations representative. These are to be consulted in the order listed:

- Criteria required by applicable State or federal regulatory agency
- Aetna Medicaid Pharmacy guidelines
- Applicable MCG Guidelines as the primary decision support for most medical diagnoses and conditions
- Level of Care Utilization System (LOCUS), behavior health services for adults
- Children and Adolescent Service Intensity Instrument (CASII) behavior health services for children and adolescents
- American Society of Addiction Medicine Criteria (ASAM) – substance use services
- Aetna Clinical Policy Bulletins (CPBs)
- Aetna Policy Council Review

If MCG state "current role remains uncertain" for the requested service, the next criteria in the hierarchy, Aetna Better Health of California CPBs, should be consulted and utilized. Medical, dental, and behavioral health management criteria and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members.

Timeliness of Decisions and Notifications to Providers, and Members

Aetna Better Health of California makes prior authorization decisions and notifies providers and applicable members in a timely manner. Unless otherwise required by the California Department of Health Care Services (DHCS). Aetna Better Health of California adheres to the following decision/notification time standards. Notice will be provided as expeditiously as the member's health condition requires, but in a timeframe not to exceed 14 calendar days following receipt of the request for service, in accordance with 42 C.F.R. 438.210)d)1. Aetna Better Health of California ensures the availability of appropriate staff between the hours of 8 a.m. and 5p.m., seven days a week, to respond to authorization requests within the established time frames. Departments that handle pre-prior authorizations must meet the timeliness standards appropriate to the services required.

Aetna Better Health of California or its delegates will authorize or provide disputed services promptly and as expeditiously as the member's health condition requires, if the services are not furnished while the appeal is pending and the plan reverses a decision to deny, limit or delay services. Aetna Better Health of California or its delegates will pay for disputed services if the member received the disputed services while an appeal is pending.

Decision/Notification Requirements

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service approval	Decision within 72 hours from receipt of request	Practitioner/Provider and Member	Oral or Written (Electronic and Written) Provider: send written within 24 hours of decision Member: send written within 2 business days of decision.
Urgent pre-service denial	Decision within 72 hours from receipt of request	Practitioner/Provider and Member	Oral or Written (Electronic and Written) Notification Provider: send written within 24 hours of decision Member: send written within 2 business days of decision
Urgent pre-service extension	The decision may be deferred and the time limit extended an additional 14 calendar days as requested by member or practitioner	Practitioner/Provider and Member	Oral or Written (Electronic and Written) Notification Provider: send written within 24 hours of decision Member: send written within 2 business days of decision.
Non-urgent pre service approval	Decision within five (5) business days of receipt of the request	Practitioner/Provider and Member	Oral or Written (Electronic and Written) Notification Provider: send written within 24 hours of decision Member: send written within 2 business days of decision
Non-urgent pre-service denial	Decision within 5 business days of receipt of the request	Practitioner/Provider and Member	Oral or Written (Electronic and Written) Notification Provider: send written within 24 hours of decision Member: send written within 2 business days of decision

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent concurrent approval	Decision within 24 hours of receipt of request	Practitioner/Provider and Member	Oral or Written (Electronic and Written) Notification Provider: send written within 24 hours of decision Member: send written within 2 business days of decision
Urgent concurrent denial	Decision within 24 hours of receipt of request	Practitioner/Provider and Member	Oral or Written (Electronic and Written) Notification Provider: send written within 24 hours of decision Member: send written within 2 business days of decision
Post-service approval	Decision within 30 calendar days from receipt of the request	Practitioner/Provider and Member	Oral or Written (Electronic and Written) Notification Provider/Member: send written notification within 30 calendar days of receipt of request
Post-service denial	Decision within 30 calendar days from receipt of the request	Practitioner/Provider and Member	Oral or Written (Electronic and Written) Notification Provider/Member: send written notification within 30 calendar days of receipt of request
Therapeutic Enteral Formula (members under 21 yrs.) approval	Within 24 hours of receipt of request	Practitioner/Provider and Member	Oral or Written (Electronic or Written) Provider: send written within 24 hours of decision Member: send written within 2 business days of decision
Therapeutic Enteral Formula (members under 21 yrs.) denial	Within 24 hours of receipt of request	Practitioner/Provider and member	Oral or Written (Electronic or Written) Provider: send written within 24 hours of decision Member: send written within 2 business days of decision
Hospice inpatient care approval	Within 24 hours of receipt of request	Practitioner/Provider and Member	Oral or Written (Electronic or Written) Provider: send written within 24 hours of decision Member: send written within 2 business days of decision
Hospice inpatient care denial	Within 24 hours of receipt of request	Practitioner/Provider and Member	Oral or Written (Electronic or Written) Provider: send written within 24 hours of decision Member: send written within 2 business days of decision

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent Extensions	Within fourteen (14) Calendar days of the request for additional information. The decision may be deferred an additional 14 calendar days upon member or provider request, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest	Practitioner/Provider and Member	Oral or Written (Electronic or Written) Provider: send written within 24 hours of decision Member: send written within 2 business days of decision
Non-urgent Extensions	Within fourteen (14) calendar days of the request ¹ The decision may be deferred an additional 14 calendar days upon member or provider request, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest	Practitioner/Provider and Member	Oral or Written (Electronic or Written) Provider: send written within 24 hours of decision Member: send written within 2 business days of decision
Termination, Suspension Reduction of Prior Authorization	At least 10 calendar days before the date of the action	Practitioner/Provider and Member	Electronic and Written

Prior Authorization Period of Validation

Prior authorization numbers are valid for the date of service authorized. The member must be enrolled and eligible on each date of service.

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, Aetna Better Health of California will assign a prior authorization number, which refers to and documents the approval. Aetna Better Health of California sends written documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request.

Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health of California makes such decisions on a case-by-case basis in consultation with Aetna Better Health of California's medical director.

Notice of Action Requirements

to deny, reduce, suspend, or terminate a prior authorization request, limits, or to authorize a service in the amount, duration or scope that is less than requested or denies payment, in whole or part, for a service.

The notice will include:

- The action that Aetna Better Health of California has or intends to take
- The specific reason for the action, customized to the member circumstances, and in easily understandable language to the member
- A reference to the benefit provision, guideline, or protocol or other similar criterion on which the denial decision was based
- The name and contact information for the physician or dentist that reviewed and denied the service
- Notification that, upon request, the provider or member, if applicable, may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based
- Notification that provider has the opportunity to discuss medical, dental, and behavioral healthcare UM denial decisions with a physician or other appropriate reviewer
- A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal
- An explanation of the appeals process, including the right to member representation (with the member's permission) and the timeframes for deciding appeals
- A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures
- The member's or provider (with written permission of the member) right to request a Medicaid State Fair Hearing and instructions about how to request a Medicaid State Fair Hearing
- A description of the expedited appeals processes for urgent preservice or urgent concurrent denials
- The circumstances under which expedited resolution is available and how to request it
- The member's right to request continued benefits pending the resolution of the appeal or pending a Medicaid Fair Hearing, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these benefits
- Translation service information
- The procedures for exercising the members rights

Continuation of Benefits

Aetna Better Health of California will continue member's benefits during the appeal process if:

- The member or the provider 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 (i.e. a network provider).
- The original period covered by the original authorization has not expired, unless inadequate notice was given to allow a member a timely appeal.

Aetna Better Health of California will continue the member's benefits until one of the following occurs:

- The member withdraws the appeal.
- A State fair hearing office issues a hearing decision adverse to the member.
- The time period or service limits of a previously authorized service has been met.

Prior Authorization and Coordination of Benefits

If other insurance is the primary payer before Aetna Better Health of California, prior authorization of a service is not required, unless it is known that the service provided is not covered by the primary payer. If the service is not covered by the primary payer, the provider must follow our prior authorization rules.

Self-Referrals

Aetna Better Health of California does not require referrals from Primary Care Providers (PCP) or treating providers. Members may self-refer access some services without an authorization from their PCP. These

services include vision care, adult dental care, family planning, minor consent services, and women's health care services. The member must obtain these self-referred services from Aetna Better Health of California's provider network, except in the case of family planning.

Member may access family planning services from any qualified provider. Members also have direct access to Women's Health Care Provider (WHCP) services. Members have the right to select their own women's health care provider, including nurse midwives participating in Aetna Better Health of California's network, and can obtain maternity and gynecological care without prior approval from a PCP.

CHAPTER 13: QUALITY MANAGEMENT

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Overview

Our Quality Management (QM) Program is an ongoing, objective, and systematic process of monitoring, evaluating, and improving the quality, appropriateness, and effectiveness of care. Aetna Better Health of California uses this approach to measure conformance with desired medical standards and develop activities designed to improve patient outcomes.

Aetna Better Health of California performs QM through a Quality Assessment and Performance Improvement (QAPI) Program with the involvement of multiple organizational components and committees. The primary goal of the QM Program is to improve the health status of members or maintain current health status when the member's condition is not amenable to improvement. The QM Program Description, QM Evaluation and performance are available upon request.

Aetna Better Health of California's QM Program is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities. These activities continuously and proactively review our clinical and operational programs and processes to identify opportunities for continued improvement. Our continuous QM process enables us to:

- Assess current practices in both clinical and non-clinical areas
- Identify opportunities for improvement
- Select the most effective interventions
- Evaluate and measure on an ongoing basis the success of implemented interventions, refining the interventions as necessary

The use of data in the monitoring, measurement and evaluation of quality and appropriateness of care and services is an integral component of Aetna Better Health of California's quality improvement process.

Aetna Better Health of California's QM Program uses an integrated and collaborative approach, involving our senior management team, functional areas within the organization and committees from the Board of Directors to the Member / Community Advisory Committee. This structure allows members and providers to offer input into our quality improvement activities. Our Medical Director oversees the QM program. The Medical Director is supported in this effort by our QM Department and the Quality Management Oversight Committee (QMOC) and subcommittees.

The primary purpose of the QAPI Program is to provide the structure and processes necessary to identify and improve clinical quality, maximize safe clinical practices and enhance member and provider satisfaction across the various settings of care within the care delivery system.

The QAPI Program strives to ensure that the services provided to ABH members conform to the standards and requirements of regulatory and accrediting agencies, including the California Department of Health Care Services (DHCS), California Department of Managed Health Care (DMHC) and the National Committee for Quality Assurance (NCQA).

Further, the purpose of the QAPI Program is to establish standards and criteria and provide processes, procedures and structures to review and monitor the care and service delivered, including accessibility, availability, and continuity of care. In accordance with 28 CCR 1300.70(a), the QAPI Program is directed by providers and there is a process to document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

Aetna Better Health strives to achieve the following primary goals:

- Implement a QM program that effectively promotes and builds quality into the organizational structure and processes of the health plan
- Conduct continual monitoring and assessment of patient care and services striving to provide health care and services to health plan members that meet accepted and appropriate medical practice standards and the needs of the health plan members and health care professionals
- Identify and analyze opportunities for improvement with implementation of actions and follow-up
- Encourage patient safety
- Maintain compliance with local, state, and federal regulatory requirements and accreditation standards

Additional committees such as Service Improvement Committee (SIC), Credentialing and Performance, Appeals/Grievance, and Quality Management/Utilization Management further support our QAPI Program. Aetna Better Health of California encourages provider participation on key medical committees. Providers may contact the Medical Director or inform their Provider Services Representative if they wish to participate. Aetna Better Health of California can be reached by calling **1-855-772-9076**.

Aetna Better Health of California's QM staff develops and implements an annual work plan, which specifies projected QM activities. Based on the work plan, we conduct an annual QM Program evaluation, which assesses the impact and effectiveness of QM activities.

Aetna Better Health of California's QM Department is an integral part of the health plan. The focus of our QM staff is to review and trend services and procedures for compliance with nationally recognized standards and recommend and promote improvements in the delivery of care and service to our members. Our QM and Medical Management Departments maintain ongoing coordination and collaboration regarding quality initiatives, care management, and disease management activities involving the care of our members.

Aetna Better Health of California's QM activities include, but are not limited to, medical record reviews, site reviews, peer reviews, satisfaction surveys, performance improvement projects, and provider profiling. Utilizing these tools, Aetna Better Health of California, in collaboration with providers, is able to monitor and reassess the quality of services provided to our members. Providers are obligated to support and meet Aetna Better Health of California's QAPI and Utilization Management program standards. Contracted participating providers are required by contract to:

- Cooperate with QI activities
- Maintain the confidentiality of member information and records
- Allow the plan to use practitioner performance data

Note: Providers must also participate in the CMS and DHCS quality improvement initiatives. Any information provided must be reliable and complete.

Identifying Opportunities for Improvement

Aetna Better Health of California identifies and evaluates opportunities for quality improvement and determines the appropriate intervention strategies through the systematic collection, analysis, and review of a broad range of external and internal data sources. The types of data Aetna Better Health of California monitors to identify opportunities for quality improvements include:

- **Formal Feedback from External Stakeholder Groups:** Aetna Better Health of California takes the lead on reaching out to external stakeholder groups by conducting one-on-one meetings, satisfaction surveys (Consumer Assessment of Healthcare Providers and Systems (CAHPS), Provider Satisfaction Survey), or focus groups with individuals, such as members and families, providers, and state and community agencies.
- **Findings from External Program Monitoring and Formal Reviews:** Externally initiated review activities, such as an annual external quality program assessments or issues identified through a state's ongoing

contract monitoring oversight process assists Aetna Better Health of California in identifying specific program activities/processes needing improvement.

- **Internal Review of Individual Member or Provider Issues:** In addition to receiving grievances and appeals from members, providers, and other external sources, Aetna Better Health of California proactively identifies potential quality of service or care issues for review through daily operations (i.e. member services, prior authorization, and care management). Through established formalized review processes (i.e., grievances, appeals, assessment of the timeliness of our care management processes, access to provider care and covered services, and quality of care), Aetna Better Health of California is able to identify specific opportunities for improving care delivered to individual members.
- **Findings from Internal Program Assessments:** Aetna Better Health of California conducts a number of formal assessments/reviews of program operations and providers that are used to identify opportunities for improvement. This includes but is not limited to: record reviews of contracted providers, credentialing/recredentialing of providers, oversight reviews of delegated activities, inter-rater reliability audits of medical review staff, annual quality management program evaluation, cultural competency assessment, and assessment of provider accessibility and availability.
- **Clinical and Non-Clinical Performance Measure Results:** Aetna Better Health of California uses an array of clinical and non-clinical performance standards (e.g., call center response times, and claim payment lag times) to monitor and evaluate operational performance. Through frequent monitoring and trending of our performance measure results, Aetna Better Health of California is able to identify opportunities for improvement in clinical and operational functions. These measures include:
 - Adherence to nationally recognized best practice guidelines and protocols
 - Prior authorization (e.g., timeliness of decisions, notices of action, service/care plan appeals)
 - Provider availability and accessibility, including:
 - Length of time to respond to requests for referrals
 - Timeliness of receipt of covered services
 - Timeliness of the implementation of members' care plans -Availability of 24/7 telephonic assistance to members and caregivers receiving home care services
- **Data Trending and Pattern Analysis:** With our innovative information management systems and data mining tools, Aetna Better Health of California makes extensive use of data trending and pattern analysis for the identification of opportunities for improvement in many levels of care.
- **Other Service Performance Monitoring Strategies:** Aetna Better Health of California uses a myriad of monitoring processes to confirm effective delivery of services to all our members, such as provider and member profiles, service utilization reports, and internal performance measures. Aspects of care that Aetna Better Health of California monitors include, but are not limited to:
 - High-cost, high-volume, and problem prone aspects of the long-term care services our members receive
 - Effectiveness of the assessment and service planning process, including its effectiveness in assessing a member's informal supports and treatment goals, planned interventions, and the adequacy and appropriateness of service utilization
 - Delivery of services enhancing member safety and health outcomes and prevention of adverse consequences, such as fall prevention programs, skin integrity evaluations, and systematic monitoring of the quality and appropriateness of home services

Potential Quality of Care (PQoC) Concerns

Aetna Better Health of California has a process for identifying Potential Quality of Care (PQoC) concerns related to our provider network including Home and Community-Based Services (HCBS), researching and resolving these care concerns in an expeditious manner, and following up to make sure needed interventions are implemented. This may include referring the issue to peer review and other appropriate external entities. In addition, Aetna Better Health of California tracks and trends PQoC cases and prepares trend reports that we organize according to provider, issue category, referral source, number of verified issues, and closure levels. Aetna Better Health of California will use these

trend reports to provide background information on providers for whom there have been previous complaints. These reports also identify significant trends that warrant review by the Aetna Credentialing and Performance Committee or identify the need for possible quality improvement initiatives.

Performance Improvement Projects (PIPs)

Performance improvement projects (PIPs), a key component of our QM Program, are designed to achieve and sustain a demonstrable improvement in the quality or appropriateness of services over time. Our PIPs follow CMS protocols. Aetna Better Health of California participates in state-mandated PIPs and selects PIP topics that:

- Target improvement in areas that will address a broad spectrum of key aspects of members' care and services over time
- Address clinical or non-clinical topics
- Identify quality improvement opportunities through one of the identification processes described above
- Reflect Aetna Better Health of California enrollment in terms of demographic characteristics, prevalence of disease and potential consequences (risks) of the disease

Our QM department prepares PIP proposals that are reviewed and approved by our Medical Director, Quality Management/Utilization Management Committee, and the Quality Management Oversight Committee (QMOC) prior to submission to DHCS for review and approval. The committee review process provides us with the opportunity to solicit advice and recommendations from other functional units within Aetna Better Health of California, as well as from network providers who are members of our Quality Management/Utilization Management Committee.

The QM department conducts ongoing evaluation of the study indicator measures throughout the length of the PIP to determine if the intervention strategies have been successful. If there has been no statistically significant improvement or even a decline in performance, Aetna Better Health of California immediately conducts an analysis to identify why the interventions have not achieved the desired effect and whether additional or enhanced intervention strategies should be implemented to achieve the necessary outcomes. This cycle continues until we achieve real and sustained improvement.

Peer Review

Peer review activities are evaluated by the Credentialing and Performance Committee. This committee may take action if a quality issue is identified. Such actions may include, but are not limited to, development of a Corrective Action Plan (CAP) with time frames for improvement, evidence of education, counseling, development of policies and procedures, monitoring and trending of data, limitations, or discontinuation of the provider's contract with the plan. The peer review process focuses on the issue identified, but, if necessary, could extend to a review of utilization, medical necessity, cost, and health provider credentials, as well as other quality issues.

The health plans peer review process adheres to Aetna Better Health of California policies, is conducted under applicable State and federal laws, and is protected by the immunity and confidentiality provisions of those laws.

The right of appeal is available to providers whose participation in the Aetna Better Health of California network has been limited or terminated for a reason based on the quality of the care or services provided. Appealable actions may include the restriction, reduction, suspension, or termination of a contract under specific circumstances.

Performance Measures

Aetna Better Health of California collects and reports clinical and administrative performance measure data to DHCS. The data enables Aetna Better Health of California and DHCS to evaluate our adherence to practice guidelines, as applicable, and improvement in member outcomes.

Satisfaction Survey

Aetna Better Health of California conducts member and provider satisfaction surveys to gain feedback regarding members and providers' experiences with quality of care, access to care, and service/operations. Aetna Better Health of California uses member and provider satisfaction survey results to help identify and implement opportunities for improvement. Each survey is described below.

Member Satisfaction Surveys

Consumer Assessment of Healthcare Providers and Systems (CAHPS) are a set of standardized surveys that assess patient satisfaction with the experience of care. CAHPS surveys (Adult and Children) are subsets of Healthcare Effectiveness Data and Information Set (HEDIS) reporting. Aetna Better Health of California contracts with a National Committee for Quality Assurance (NCQA)-certified vendor to administer the survey according to HEDIS survey protocols. The survey is based on randomly selected members and summarizes satisfaction with the health care experience.

Provider Satisfaction Surveys

Aetna Better Health of California conducts an annual provider survey to assess satisfaction with our operational processes. Topics include claims processing, provider training and education, and Aetna Better Health of California's response to inquiries.

External Quality Review (EQR)

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1932(c), (2) [42 U.S.C. 1396u-2] for States to contract with an independent external review body to perform an annual review of the quality of services furnished under State contracts with the Medi-Cal Plans, including the evaluation of quality outcomes, timeliness, and access to services. External Quality Review (EQR) refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to members. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders.

Aetna Better Health of California cooperates fully with external clinical record reviews assessing our network's quality of services, access to services, and timeliness of services, as well as any other studies determined necessary by DHCS. Aetna Better Health of California assists in the identification and collection of any data or records to be reviewed by the independent evaluation team. Aetna Better Health of California also provides complete records to the External Quality Review Organization (EQRO) in the time frame allowed by the EQRO. Aetna Better Health of California's contracted providers are required to provide any records that the EQRO may need for its review within thirty (30) days of request.

The results of the EQR are shared with providers and incorporated into our overall QM and medical management programs as part of our continuous quality improvement process.

Provider Profiles

In an effort to promote the provision of quality care, Aetna Better Health of California profiles providers who meet the minimum threshold of members in their practices, as well as the minimum threshold of members for specific profiling measures. Individual providers and practices are profiled for multiple measures and results are compared with colleagues in their specialty. In addition, we profile providers to assess adherence to evidence-based guidelines for their patients enrolled in disease management.

The Provider Profiling Program is designed to share standardized utilization data with physicians in an effort to improve clinical outcomes. Aetna Better Health of California's profiling program is intended to support clinical decision-making and patient engagement as providers often have little access to information about how they are managing their members or about how practice patterns compare to those of their peers. Additional goals of the Provider Profiling Program are to improve the provider- patient relationship to reduce unwanted variation in care and improve efficacy of patient care.

Aetna Better Health of California includes several measures in the provider profile, which include but are not limited to:

- Frequency of individual patient visits to the PCP
- EPSDT services for the pediatric population
- HEDIS-type screening tests and evidence-based therapies (i.e. appropriate asthma management linked with correct use of inhaled steroids)
- Use of medications

- ER utilization and inpatient service utilization
- Referrals to specialists and out-of-network providers

Aetna Better Health of California distributes profile reports to providers so they can evaluate:

- Potential gaps in care and opportunities for improvement
- Information indicating performance for individual cases or specific disease conditions for their patient population
- A snapshot of their overall practice performance relative to evidence-based quality metrics

Aetna Better Health of California's CMO and medical directors regularly visit individual network providers to interpret profile results, review quality data, and discuss any new medical guidelines. Our CMO and medical directors investigate potential utilization or quality of care issues that may be identified through profiles. Aetna Better Health of California's medical leadership is committed to collaborating with providers to find ways to improve patient care.

Clinical Practice Guidelines

The evidenced-based clinical practice guidelines used by Aetna Better Health of California represent best practices and are based on national standards, reasonable medical evidence, and expert consensus. Prior to being recommended for use, the guidelines are reviewed and approved by the health plan chief medical officer, applicable medical committees and, if necessary, external consultants. Clinical practice guidelines are reviewed at least every two years, or as often as new information is available.

Clinical guidelines are made available to providers on the Aetna Better Health of California website; providers are informed of the availability of new guidelines and updates in the provider newsletter. Providers may request a copy of a guideline at any time by contacting their provider services representative or the Aetna Better Health of California office of the chief medical officer.

Clinical Guidelines: [AetnaBetterHealth.com/California/providers/guidelines](https://www.aetna.com/better-health/california/providers/guidelines)

CHAPTER 14: ADVANCE DIRECTIVES (THE PATIENT SELF DETERMINATION ACT)

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Providers are required to comply with the Patient Self-Determination Act (PSDA), Physician Orders for Life Sustaining Treatment Act (POLST) and the California Advance Directive rules (Probate Code Section 4700-4701), including all other State and federal laws regarding advance directives for adult members.

Advance Directives

Aetna Better Health of California defines advance directives as a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.

The advance directive must be prominently displayed in the adult member's medical record. Requirements include:

- Providing written information to adult members regarding each individual's rights under State law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections).
- Documenting in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed.
- Not discriminating against a member because of his or her decision to execute or not execute an advance directive and not making it a condition for the provision of care.
- Educating staff on issues related to advance directives as well as communicating the member's wishes to attending staff at hospitals or other facilities.
- Educate patients on Advance Directives (durable power of attorney and living wills).

For additional information about medical record requirements, please visit Chapter 03 of this Manual.

Patient Self-Determination Act (PSDA)

The Patient Self-Determination Act (PSDA), passed in 1990 and instituted on December 1, 1991, encourages all people to make choices and decisions now about the types and extent of medical care they want to accept or refuse should they become unable to make those decisions due to illness.

The PSDA requires all health care agencies (hospitals, long-term care facilities, and home health agencies) receiving Medicare and Medicaid reimbursement to recognize the living will and power of attorney for health care as advance directives. Aetna Better Health of California requires our providers to comply with this act.

For additional information about the PSDA, please visit www.gapna.org/patient-self-determination-act-psda.

Physician Orders for Life Sustaining Treatment (POLST) Act

Aetna Better Health of California requires providers to comply with the Physician Orders for Life Sustaining Treatment Act (POLST). The creation of this act allows members to indicate their preferences and instructions regarding life-sustaining treatment. This act implements the Physician's Order for Life-Sustaining Treatment (POLST) program. The POLST protocol requires a health care professional to discuss available treatment options with seriously ill members (or their advocate/family member), and these preferences are then documented on a standardized medical form that the member keeps with them.

The form must be signed by a member's attending provider or advanced practice nurse. This form then must become part of a member's medical record, as this form will follow the member from one healthcare setting to another, including hospital, home, nursing home, or hospice.

Concerns

Provider Concerns & Complaints

Complaints concerning noncompliance may be filed with the Department of Managed Health Care (DMHC) Provider Complaint line toll-free at **1-877-525-1295**.

Member Concerns & Complaints

Complaints concerning noncompliance may be filed with the Department of Managed Health Care (DMHC) by calling toll-free at **1-888-466-2219**.

CHAPTER 15: ENCOUNTERS, BILLING AND CLAIMS

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Aetna Better Health of California processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable State and federal laws, rules and regulations. Aetna Better Health of California will not pay claims submitted by a provider who is excluded from participation in any Medi-Cal Programs, or any program under federal law, or is not in good standing with the Department of Health Care Services (DHCS).

Aetna Better Health of California uses our business application system to process and adjudicate claims. Both electronic and manual claims submissions are accepted. To assist us in processing and paying claims efficiently, accurately and timely, Aetna Better Health of California encourages providers to submit claims electronically. To facilitate electronic claims submissions, Aetna Better Health of California has developed a business relationship with Change Healthcare (formerly Emdeon). Aetna Better Health of California receives Electronic Data Interchange (EDI) claims directly from this clearinghouse, processes them through pre-import edits to maintain the validity of the data, HIPAA compliance, and member enrollment, and then uploads them into our business application each business day. Within twenty-four (24) hours of file receipt, Aetna Better Health of California provides production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

Encounters

Billing Encounters and Claims Overview

Our Claims Inquiry Claims Research (CICR) Department is responsible for claims adjudication; resubmissions and claims inquiry/research.

Aetna Better Health of California is required to process claims in accordance with Medicare and Medicaid claim payment rules and regulations.

- Providers must use valid International Classification of Disease, 10th Edition, Clinical Modification (ICD-10 CM) codes, and code to the highest level of specificity. Complete and accurate use of The Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the Risk Adjustment Processing System. Important notes: The ICD10 CM codes must be to the highest level of specificity: assign three-digit codes only if there are no four-digit codes within that code category, assign four-digit codes only if there is no fifth-digit sub-classification for that subcategory and assign the fifth-digit sub-classification code for those sub-categories where it exists.
- Report all secondary diagnoses that impact clinical evaluation, management, and treatment.
- Report all relevant V-codes and E-codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Review of the medical record entry associated with the claim should obviously indicate all diagnoses that were addressed were reported.

Again, failure to use current coding guidelines may result in a delay in payment and rejection of a claim.

CMS Risk Adjustment Data Validation

Risk Adjustment Data Validation (RADV) is an audit process to verify the integrity and accuracy of risk-adjusted payment. CMS may require us to request medical records to support randomly selected claims to verify the accuracy of diagnosis codes submitted.

It is important for providers and their office staff to be aware of risk adjustment data validation activities because we may request medical record documentation. Accurate risk-adjusted payment depends on the accurate diagnostic coding derived from the member's medical record.

The Balanced Budget Act of 1997 (BBA) specifically required implementation of a risk-adjustment method no later than January 1, 2000. In 2000-2001, encounter data collection was expanded to include outpatient hospital and physician data. Risk adjustment is used to fairly and accurately adjust payments made to Aetna Better Health of California by CMS based on the health status and demographic characteristics of a member. CMS requires us to submit diagnosis data regarding physician, inpatient, and outpatient hospital encounters on a quarterly basis, at minimum.

The Centers for Medicare and Medicaid Services (CMS) uses the Hierarchical Condition Category (HCC) payment model referred to as CMS-HCC model. This model uses the ICD-10 CM as the official diagnosis code set in determining the risk-adjustment factors for each member. The risk factors based on HCCs are additive and are based on predicted expenditures for each disease category. For risk-adjustment purposes, CMS classifies the ICD-10 CM codes by disease groups known as HCCs.

Providers are required to submit accurate, complete, and truthful risk adjustment data to us. Failure to submit complete and accurate risk adjustment data to CMS may affect payments made to Aetna Better Health of California and payments made by Aetna Better Health of California to the provider organizations delegated for claims processing.

Certain combinations of coexisting diagnoses for a member can increase their medical costs. The CMS hierarchical condition categories HCC model for coexisting conditions that should be coded for hospital and physician services are as follows:

- Code all documented conditions that coexist at time of encounter/visit and that require or affect member care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Providers and hospital outpatient departments should not code diagnoses documented as "probable," "suspected," "questionable," "rule out" or "working" diagnosis. Rather, providers and hospital outpatient departments should code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Annually, CMS conducts a medical record review to validate the accuracy of the risk-adjustment data submitted by Aetna Better Health of California. Medical records created and maintained by providers must correspond to and support the hospital inpatient, outpatient, and physician diagnoses submitted by the provider to us. In addition, regulations require that providers submit samples of medical records for validation of risk-adjustment data and the diagnoses reported to CMS, as required by CMS. Therefore, providers must give access to and maintain medical records in accordance with Medicare laws, rules, and regulations. The Centers for Medicare and Medicaid Services (CMS) may adjust payments to us based on the outcome of the medical record review.

For more information related to risk adjustment, visit the Centers for Medicare and Medicaid Services website at <http://csscooperations.com/>.

Billing and Claims

When to Bill a Member

All providers must adhere to federal financial protection laws and are prohibited from balance billing any member beyond the member's cost sharing, if applicable.

A member may be billed **ONLY** when the member knowingly agrees to receive non-covered services under the Medi-Cal Program:

- Provider **MUST** notify the member in advance that the charges will not be covered under the program.
- Provider **MUST** have the member sign and date a statement agreeing to pay for the services, letting the member know how much they will have to pay, why they are not covered for the service(s), and place the document in the member’s medical record.

When to File a Claim

All claims and encounters must be reported to us, including prepaid services.

Timely Filing of Claim Submissions

In accordance with contractual obligations, claims for services provided to a member must be received in a timely manner. Our timely filing limitations are as follows:

- **New Claim Submissions** – Claims must be filed on a valid claim form within 180 days from the date services were performed, unless there is a contractual exception. For hospital inpatient claims, date of service means the date of discharge of the member.
- **Claim Resubmission** – Claim resubmissions must be filed within 180 days from the date of adverse determination of a claim.

Failure to submit claims and encounter data within the prescribed period may result in payment delay and denial.

Prompt Pay Requirements

- Ninety percent (90%) of all clean claims must be paid within thirty (30) days of the date of receipt.
- Ninety-nine percent (99%) of all clean claims must be paid within ninety (90) calendar days of the date of receipt.

How to File a Claim

1) Select the appropriate claim form (refer to table below).

Service	Claim Form
Medical and professional services	CMS 1500 Form
Hospital inpatient, outpatient, skilled nursing and emergency room services	CMS UB-04 Form
Dental services that are considered medical services (oral surgery, anesthesiology)	CMS 1500 Form

Instructions on how to fill out the claim forms can be found on our website at

AetnaBetterHealth.com/California.

- 2) Complete the claim form.
- a) Claims must be legible and suitable for imaging and microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
 - b) The claim form may be returned unprocessed (unaccepted) if illegible or poor quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.
- 3) Submit original copies of claims electronically or through the mail (do NOT fax). To include supporting documentation, such as members’ medical records, clearly label and send to Aetna Better Health of California at the correct address.
- a) Electronic Clearing House
Providers who are contracted with us can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim

sent, and minimizes clerical data entry errors. Additionally, a Level Two report is provided to your vendor, which is the only accepted proof of timely filing for electronic claims.

- Change Healthcare (formerly Emdeon) is the EDI vendor we use.
- Contact your software vendor directly for further questions about your electronic billing.
- Contact our Provider Services Department for more information about electronic billing.

All electronic submission will be submitted in compliance with applicable law including HIPAA regulations and Aetna Better Health of California policies and procedures.

b) Through the Mail

Claims	Mail To	Electronic Submission
Medical	Aetna Better Health of California Inc. P.O. Box 982971 El Paso, TX 79998-2971	Through Electronic Clearinghouse www.changehealthcare.com/ or Change Healthcare “WebConnect” https://office.emdeon.com/secure/scripts/inq.dll?MfcISAPICCommand=Login

About WebConnect

Aetna Better Health of California uses Change Healthcare WebConnect. WebConnect is a web-based solution set that simplifies the everyday tasks the provider practices by integrating eligibility and benefits verification, claims and payment management as well as clinical tools all into one easy to use application. There are no provider costs for specialized software or per-transaction fees, even providers who previously only interfaced by submitting claims manually may utilize WebConnect for automated payer interaction.

Features

- Secure personalized web portal for submitting providers
- Automated electronic batch claim submission & real-time patient eligibility, benefit verification, referrals, pre certs, authorizations, claim inquiry and more
- Fast implementation
- Real-time provider enrollment offers immediate electronic capability

Benefits

- Improves auto-adjudication rates
- Increases automation and improves efficiency
- Reduces call center volumes and associated expenses
- Eliminates requirement for capital investments in IT and staffing related to internal portal development and maintenance
- Drives providers directly to payers' websites
- Improves provider satisfaction

Please visit Change Healthcare to gain access:

<https://office.emdeon.com/secure/scripts/inq.dll?MfcISAPICCommand=Login>

Correct Coding Initiative

Aetna Better Health of California follows the same standards as NCCI’s Medicaid performs edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please feel free to visit www.cms.hhs.gov/NationalCorrectCodInitEd/.

Aetna Better Health of California utilizes Claim Check as our comprehensive code auditing solution that will assist payers with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies. Additional information will be released shortly regarding provider access to our unbundling software through Clear Claim Connection.

Clear Claim Connection is a web-based stand-alone code auditing reference tool designed to mirror our comprehensive code auditing solution through ClaimCheck. It enables us to share with our providers the claim auditing rules and clinical rationale inherent in ClaimCheck.

Providers will have access to Clear Claim Connection through our website through a secure login. Clear Claim Connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Correct Coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Incorrect Coding

Examples of incorrect coding include:

- “Unbundling” - fragmenting one service into components and coding each as if it were a separate service
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate
- Down coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate

Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Aetna Better Health of California can request copies of operative reports or office notes to verify services provided.

Common modifier issue clarification is below:

- **Modifier 59 – Distinct Procedural Services** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).
- **Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.
- **Modifier 50 – Bilateral Procedure** - If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. We follow the same billing process as CMS and HFS when billing for bilateral procedures. Services should be billed on one line reporting one unit with a 50 modifier.
- **Modifier 57 – Decision for Surgery** – must be attached to an Evaluation and Management code when a decision for surgery has been made. We follow CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period. CMS guidelines found in the Medicare Claims Processing Manual, [Chapter 12](#) –

“Carriers pay for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT modifier “-57” to indicate that the service resulted in the decision to perform the procedure. Carriers may not pay for an evaluation and management service billed with the CPT modifier “-57” if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period.”

Please refer to your Current Procedural Terminology (CPT) Manual for further detail on all modifier usage.

Checking Status of Claims

Providers may check the status of a claim by accessing our secure website or by calling the Claims Inquiry Claims Research (CICR) Department. To check the status of a disputed, resubmitted, and reconsidered claim, please contact the CICR Department.

Online Status through Aetna Better Health of California’s Secure Website

Aetna Better Health of California encourages providers to take advantage of using our online Provider Secure Web Portal at [AetnaBetterHealth.com/California](https://www.aetna.com/betterhealth/california), as it is quick, convenient and can be used to determine status (and receipt of claims) for multiple claims, paper and electronic. The Provider Secure Web Portal is located on the website. Provider must contact us, and we will register him/her to use our portal. Please see [Chapter 4](#) for additional details surrounding the Provider Secure Web Portal.

Calling the Claims Inquiry Claims Research Department

The Claims Inquiry Claims Research (CICR) Department is also available to:

- Answer questions about claims.
- Assist in resolving problems or issues with a claim.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a particular claim.
- Correct errors in claims processing:
 - Excludes corrections to prior authorization numbers (providers must call the Prior Authorization Department directly).
 - Excludes rebilling a claim (the entire claim must be resubmitted with corrections).
- Please be prepared to give the service representative the following information:
 - Provider name or National Provider Identification (NPI) number with applicable suffix if appropriate
 - Member name and member identification number
 - Date of service.
 - Claim number from the remittance advice on which you have received payment or denial of the claim.

Claim Resubmission

Providers have 90 calendar days from the paid date to resubmit a revised version of a processed claim. The review and reprocessing of a claim do not constitute reconsideration or claim dispute.

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors

Include the following information when filing a resubmission:

- Use the Resubmission Form located on our website.
- An updated copy of the claim. All lines must be rebilled. A copy of the original claim (reprint or copy is acceptable).
- A copy of the remittance advice on which the claim was denied or incorrectly paid
- Any additional documentation required.
- A brief note describing requested correction
- Clearly label as “Resubmission” at the top of the claim in black ink and mail to appropriate claims address.

Resubmissions may not be submitted electronically. Failure to mail and accurately label the resubmission to the correct address will cause the claim to deny as a duplicate.

Please note: Providers will receive an EOB when their disputed claim has been processed. Providers may call our CICR Department during regular office hours to speak with a representative about their claim dispute. The CICR Department will be able to verbally acknowledge receipt of the resubmission, reconsideration and the claim dispute. Our staff will be able to discuss, answer questions, and provide details about status. Providers can review our Secure Web Portal to check the status of a resubmitted/reprocessed and adjusted claim. These claims will be noted as "Paid" in the portal. To view our portal, please click on the portal tab, which is located under the provider page, which can be found on the following website: AetnaBetterHealth.com/California

Instruction for Specific Claims Types

Aetna Better Health of California General Claims Payment Information

Our claims are always paid in accordance with the terms outlined in your provider contract. Prior authorized services from Non-Participating Health Providers will be paid in accordance with Original Medicare claim processing rules.

Skilled Nursing Facilities (SNF)

Providers submitting claims for SNFs should use CMS UB-04 Form.

Providers must bill in accordance with standard Medicare RUGS billing requirement rules for Aetna Better Health of California, following consolidated billing. For additional information regarding CMS Consolidated Billing, please refer to the following CMS website address: www.cms.gov/SNFPPS/05_ConsolidatedBilling.asp

Home Health Claims

Providers submitting claims for Home Health should use UB forms not a CMS 1500 for Skilled Nursing codes as part of home health. Providers must bill in accordance with contract. Non-Participating Health Providers must bill according to CMS HHPPS requirement rules for Aetna. For additional information regarding CMS Home Health Prospective Payment System (HHPPS), please refer to the following CMS website address: www.cms.gov/HomeHealthPPS/.

Durable Medical Equipment (DME) Rental Claims

Providers submitting claims for Durable Medical Equipment (DME) Rental should use CMS 1500 Form.

DME rental claims are only paid up to the purchase price of the durable medical equipment.

Units billed for the program equal 1 per month. Units billed for Medicaid equal the amount of days billed. Since appropriate billing for CMS is 1 Unit per month, in order to determine the amount of days needed to determine appropriate benefits payable under Medicaid, the claim requires the date span (from and to date) of the rental. Medicaid will calculate the amount of days needed for the claim based on the date span.

Same Day Readmission

Providers submitting claims for inpatient facilities should use CMS UB-04 Form.

There may be occasions where a member may be discharged from an inpatient facility and then readmitted later that same day. We define same day readmission as a readmission with twenty-four (24) hours.

Example: Discharge Date: 10/2/10 at 11 a.m.

Readmission Date: 10/3/10 at 9 a.m.

Since the readmission was within twenty-four (24) hours, this would be considered a same day readmission per above definition.

Hospice Claims

Aetna Better Health will cover and ensure the provision of hospice care services as defined in Sections 1905(o)(1) of the Social Security Act. Aetna Better Health will ensure that Members and their families are fully informed of the availability of hospice care as a covered service and the methods by which they may elect to receive these services. Services shall be limited to individuals who have been certified as terminally ill with a life expectancy of six (6) months or less if the terminal illness runs its normal course and who directly or through their representative voluntarily elect to receive such benefits in lieu of other care as specified. However, for a member under age 21, a voluntary election of hospice care shall not constitute a waiver of any rights of that member to be provided with, or to have payment made for covered services that are related to the treatment of that member's condition for which a diagnosis of terminal illness has been made.

For Members who have elected hospice care, Aetna Better Health will arrange for continuity of medical care, including maintaining established patient-provider relationships, to the greatest extent possible. Aetna Better Health will cover the cost of all hospice care provided. Aetna Better Health is also responsible for all medical care not related to the terminal condition.

Admission to a nursing facility of a Member who has elected covered hospice services as described in 22 CCR 51349, does not affect the Member's eligibility for enrollment under the GMC Contract. Hospice services are Covered Services under the GMC and are not long term care services regardless of the Member's expected or actual length of stay in a nursing facility.

HCPCS Codes

There may be differences in what codes can be billed for Medicare versus Medicaid. We follow Medicare billing requirement rules, which could result in separate billing for claims under Aetna. While most claims can be processed under both Medicare and Medicaid, there may be instances where separate billing may be required.

Remittance Advice

Provider Remittance Advice

Aetna Better Health of California generates checks weekly. Claims processed during a payment cycle will appear on a remittance advice ("remit") as paid, denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to verify proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Call our Provider Services Department if you are interested in receiving electronic remittance advices.

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Better Health of California for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to Aetna Better Health of California due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of

REVERSED in the claim detail header with a non-zero Refund Amount listed.

- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to Aetna Better Health of California after this payment cycle. This will result in a negative Amount Paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the Electronic Funds Transfer (EFT) Reference # and EFT Amount are listed along with the last four digits of the bank account the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.
- The Benefit Plan refers to the line of business applicable for this remit. Tax Identification Number (TIN) refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
 - Member Name
 - ID
 - Birth Date
 - Account Number
 - Authorization ID, if obtained
 - Provider Name
 - Claim Status
 - Claim Number
 - Refund Amount, if applicable
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.
- The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

An electronic version of the Remittance Advice can be attained. In order to qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through EDI and receive payment for claim by EFT. You must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact our Provider Services Department for assistance with this process. Payment for the Program will be made on separate checks, one check from Medicare, and one check from Medicaid.

Claims Submission

Claims Filing Formats

Providers can elect to file claims with Aetna Better Health of California in either an electronic or a hard copy format. Claims must be submitted using either the CM 1500 or UB 04 formats, based on your provider type as detailed below.

Electronic Claims Submission

- In an effort to streamline and refine claims processing and improve claims payment turnaround time, Aetna Better Health of California encourages providers to electronically submit claims, through Emdeon.
- Please use the Payer ID number 128CA when submitting claims to Aetna Better Health of California for both CMS 1500 and UB 04 forms. You can submit claims by visiting Change Healthcare/Emdeon at www.changehealthcare.com/. Before submitting a claim through your clearinghouse, please verify that your clearinghouse is compatible with Emdeon.

Important Points to Remember

- Aetna Better Health of California does not accept direct EDI submissions from its providers.
- Aetna Better Health of California does not perform any 837 testing directly with its providers, but performs such testing with Change Healthcare.
- For electronic resubmissions, providers must submit a frequency code of 7 or 8. Any claims with a frequency code of 5 will not be paid.

- Providers must be ICD-10 compliant upon roll out.

Paper Claims Submission

Providers can submit hard copy CM 1500 or UB 04 claims directly to Aetna Better Health of California via mail to the following address:

Aetna Better Health of California
P.O. Box 982971
El Paso, TX 7998-2971

Aetna Better Health is partnering with Change Healthcare to introduce the new EFT/ERA Registration Services (EERS), a better and more streamlined way for our providers to access payment services. EERS will give payees multiple ways to set up EFT and ERA in order to receive transactions from multiple payers. If a provider's tax identification number (TIN) is active in multiple states, a single registration will auto-enroll the payee for multiple payers. Registration can also be completed using a national provider identifier (NPI) for payment across multiple accounts.

All Aetna Better Health plans will migrate payee enrollment and verification to EERS. To enroll in EERS, please visit <https://payerenrollservices.com/>.

Risk Pool Criteria

If the claims paid exceed the revenues funded to the account, the providers will fund part or the entire shortfall. If the funding exceeds paid claims, part or all of the excess is distributed to the participating providers.

Encounter Data Management (EDM) System

Aetna Better Health of California uses an Encounter Data Management (EDM) System that warehouses claims data and formats encounter data to DHCS requirements. The EDM System also warehouses encounter data from vendors, and formats it for submission to DHCS. We use our state-of-the-art EDM System to monitor data for accuracy, timeliness, completeness and we then submit encounter data to DHCS. Our EDM System processes CMS1500, UB04 (or UB92), Dental, Pharmacy and Long Term Care claims and the most current coding protocols (e.g., standard CMS procedure or service codes, such as ICD-9, CPT-4, HCPCS-I, II). Our provider contracts require providers to submit claims on the approved claim form and each claim must contain the necessary data requirements. Part of our encounter protocol is the requirement for providers to utilize NDC coding in accordance with the Department's requirements.

The EDM System has top-of-the-line functionality to accurately, and consistently track encounters throughout the submission continuum including collection, validation, reporting, and correction. Our EDM System is able to electronically accept a HIPAA-compliant 837 (I and P) electronic claim transaction, 835 Claim Payment/Advice transaction and the NCPDP D.O. or PAH transaction in standard format and we require our providers and their clearinghouses to send electronic claims in these formats.

We collect claims information from multiple data sources into the EDM System for processing, including data from our QNXT™ claims adjudication system as well as data from third-party vendors under contract to process various claims, such as dental, vision, transportation and pharmacy. Our EDM System accommodates all data sources and provides a single repository for the collection of claims/encounters. Through our EDM System, we conduct a coordinated set of edits and data checks and identify potential data issues at the earliest possible stage of the process. Below we describe in more detail the different checkpoints.

Claims Processing

Our business application system has a series of active claim edits to determine if the appropriate claim fields contain the required values. We deny, completely or in part, claims submitted without required information or with invalid information. The provider is required to resubmit the claim with valid information before they receive payment. After adjudication and payment, we export claims data from our business application system into our EDM System. Our Encounter Management Unit validates the receipt of all claims data into EDM System using a transfer validation

report. The Encounter Management Unit researches, tracks, and reports any discrepancy until that discrepancy is completely resolved.

Encounter Staging Area

One of the unique features of our EDM System is the Encounter Staging Area. The Encounter Staging Area enables the Encounter Management Unit to evaluate all data files from our business application system and third party vendors (e.g., Pharmacy Benefit Management, dental, transportation, or vision vendors) for accuracy and completeness prior to loading into the EDM System. We maintain encounters in the staging area until the Encounter Management Unit validates that each encounter contains all required data and populated with appropriate values.

Our Encounter Management Unit directs, monitors, tracks, and reports issue resolution. The Encounter Management Unit is responsible for tracking resolution of all discrepancies.

Encounter Data Management (EDM) System Scrub Edits

This EDM System feature allows the Encounter Management Unit to apply DHCS edit profiles to identify records that may be unacceptable to the DHCS. Our Encounter Management Unit is able to customize our EDM System edits to match the edit standards and other requirements of the DHCS. This means that we can align our encounter edit configuration with the DHCS's configuration to improve encounter acceptance rates.

Encounter Tracking Reports

Encounter Tracking Reports are another unique feature of our EDM System. Reports are custom tailored for Aetna Better Health of California. Our Encounter Management Unit uses a series of customized management reports to monitor, identify, track, and resolve problems in the EDM System or issues with an encounter file. Using these reports our Encounter Management Unit is able to identify the status of each encounter in the EDM by claim adjudication date and date of service. Using these highly responsive and functional reports, our Encounter Management Unit can monitor the accuracy, timeliness, and completeness of encounter transactions from entry into EDM System, submission to and acceptance by the Department. Reports are run to verify that all appropriate claims have been extracted from the claims processing system.

Data Correction

As described above, the Encounter Management Unit is responsible for the EDM System. This responsibility includes managing the data correction process should it be necessary to resubmit an encounter due to rejection of the encounter by the Department.

Our Encounter Management Unit uses two processes to manage encounter correction activities:

- 1) Encounters requiring re-adjudication and those where re-adjudication is unnecessary. If re-adjudication is unnecessary, the Encounter Management Unit will execute corrections to allow resubmission of encounter errors in accordance with the Department encounter correction protocol.
- 2) Encounter errors that require claim re-adjudication are reprocessed in the appropriate claim system, the adjusted claim is imported into the EDM for resubmission to the Department in accordance with the encounter correction protocol, which is tailored to the Department's requirements. The Encounter Data Management System (EDM) generates, as required, the appropriate void, replacement and corrected records.

Although our data correction procedures enable the Encounter Management Unit to identify and correct encounters that failed the Department's acceptance process we prefer to initially process and submit accurate encounters. We apply lessons learned through the data correction procedures to improve our EDM System scrub and edit described above. In this way, we will expand our EDM System scrub edits to improve accuracy of our encounter submissions and to minimize encounter rejections. This is part of our continuous process improvement protocol.

Our Encounter Management Unit is important to the timely, accurate, and complete processing and submission of encounter data to the DHCS. Our Encounter Management Unit has specially trained correction analysts with experience, knowledge, and training in encounter management, claim adjudication, and claim research. This substantial skill base allows us to research and adjust encounters errors accurately and efficiently. Additionally, the unit includes technical analysts who perform the data extract and import functions, perform data analysis, and are responsible for oversight and monitoring of encounter files submissions to the DHCS. The team includes a technical

supervisor and a project manager to monitor the program.

Another critical step in our encounter data correction process is the encounter error report. We generate this report upon receipt of response files from the Department and give our Encounter Management Unit critical information to identify and quantify encounter errors by type and age. These data facilitate the monitoring and resolution of encounter errors and supports the timely resubmission of corrected encounters.

CHAPTER 16: GRIEVANCE SYSTEM

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Member Grievance System Overview

Members or their designated representative can file a request for reconsideration or express dissatisfaction with Aetna Better Health of California orally or in writing. Requests for reconsideration are classified as an appeal; see “Standard Appeal” and “Expedited Appeal.” All other expressions of dissatisfaction are classified as a grievance; see “Standard Grievance” and “Expedited Grievance”. When the grievance is received by phone and can be resolved by the next business day and it is not related to reconsideration or an appeal it is classified as an exempt grievance, see “Exempt Grievance.”

A representative is someone who acts on the member’s behalf, including but not limited to a family member, friend, guardian, provider, or an attorney. Representatives must be designated in writing. A network provider, acting on behalf of a member, and with the member’s written consent, may file a grievance or appeal with Aetna Better Health of California. Members’ and their representatives including providers with written consent may also file an Independent Medical Review (IMR) or Medi-Cal State Fair Hearing as appropriate. **When a provider acts on behalf of a member the request follows the member appeal and grievance processes and timeframes.**

Aetna Better Health of California informs members and providers of the grievance system processes for exempt grievances, grievances, appeals, IMRs and Medi-Cal State Fair Hearings. This information is also contained in the Member Handbook and is available on the Aetna Better Health of California website. When requested, we give members reasonable assistance in completing forms and taking other procedural steps. Our assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability at no cost to the member/potential member.

Aetna Better Health of California will ensure that no punitive action is taken in retaliation against a member who requests an appeal or grievance or against a provider who requests an expedited resolution or supports a member’s appeal or grievance. Providers may not discriminate or initiate disenrollment of a member for filing a grievance or appeal with Aetna Better Health of California.

Aetna Better Health of California’s processes for resolving member grievances and appeals are described below.

Exempt Grievance

Exempt grievances are defined as grievances received over the telephone that is not coverage disputes, medical necessity related disputes, or experimental or investigational treatment disputes. Exempt grievances are resolved by the next business day following receipt. *If the exempt grievance case cannot be resolved by the next business day it will be transferred to the standard grievance process maintaining the original received date.*

Standard Grievance

Standard grievances are defined as written or oral expressions of dissatisfaction regarding Aetna Better Health and/or a provider, including quality of care concerns, and shall include a complaint or dispute. Standard grievances may be submitted by telephone, facsimile, email, or online through Aetna Better Health's website. Standard grievances are resolved within thirty (30) calendar days following receipt.

Members, or their designated representatives, may submit a grievance either in writing or by calling our Member Services line or other health plan staff.

We will acknowledge standard grievance in writing within five (5) calendar days of receipt that informs the grievant of the following:

- The grievance has been received
- Date of receipt
- The name and telephone number and address of Aetna Better Health representative who may be contacted about the grievance

Our goal is to resolve grievances as quickly as possible and notify the member or representative of the resolution in writing within two (2) calendar days from the resolution and within the thirty (30) calendar day timeframe. Aetna Better Health will notify the member in writing if the grievance has not been resolved within 30 days and provide an estimated completion date.

Expedited Grievance

Expedited Grievances are defined as grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. These requests are classified and processed as an expedited appeal, see “Expedited Appeal”.

In cases where the grievance is filed as a result of Aetna Better Health denying expedited processing of an appeal or prior authorization or when Aetna Better Health takes an extension on the processing time of an appeal or prior authorization.

Members, or their designated representatives, may submit an expedited grievance either in writing through facsimile, email, United States postal mail, online through the Aetna Better Health website or by calling our Member Services line or other health plan staff.

We will acknowledge expedited grievances verbally or in writing at the time of receipt. Verbal acknowledgements will be documented and will include notification to the member that the member may immediately submit a grievance to the Department. The acknowledgment will be followed by a written statement on the decision or the pending status of the expedited appeal to both the member and the Department, 72 hours of receipt.

Standard Appeal

A standard appeal is defined as a grievance which is a request for reconsideration of an adverse determination of a request for a health care service, supply, or device for a member.

Members and their designated representatives including a provider can file an appeal or formal request directly with us to reconsider a decision, either in writing or verbally by calling into Member Services, Provider Services, or by calling any other health plan staff. The date of the verbal Appeal establishes the filing date for the Appeal and verbal Appeals shall be followed by a written, signed Appeal. Members have 60 days from the date of the Notice of Action letter to file an appeal. In the event the Aetna Better Health of California does not receive a written, signed Appeal from the member, we shall neither dismiss nor delay resolution of the Appeal.

The Notice of Action letter from the initial denial describes the member’s appeal rights and includes a request for additional clinical documentation that could assist in verifying the medical necessity of the desired services. The member or their designated representative may present supporting evidence in person or in writing, either on or before the appeal meeting date. During this time, the member or their designated representative may contact us to request a copy of the member’s file or clinical records that will be reviewed during the appeals process. There is no cost to the member.

Appeals will be reviewed by the Appeal Committee. The Committee includes an appropriately licensed clinical peer reviewer with expertise in the same or similar specialty as the service that is the subject of the appeal, who were not involved in the initial determination process, and are not a subordinate of any person involved in the initial decision making process. The deciding health care professional or their designee will approve and sign the decision.

We execute the appeal process with the utmost regard to protecting the confidentiality of protected health information in compliance with our privacy policies and HIPAA requirements. In most cases, we decide the appeal within 30 calendar days.

Expedited Appeal

An expedited appeal is defined as a request for reconsideration of an adverse determination of a request for a health care service, supply, or device for a member that involves an imminent and serious threat to the health of the patient,

including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.

Members and their designated representatives including a provider can file an expedited appeal or formal request directly with us to reconsider a decision, either in writing or verbally by calling into Member Services, Provider Services, or by calling any other health plan staff.

While most appeals will follow the standard process and are resolved within the 30-calendar day requirement, there are times when we expedite appeals. Some situations may require a faster decision. In those cases, we expedite the decision-making process. This may include situations where:

- A member's life, health, or ability to attain, maintain, or regain maximum function may be at risk
- The treating provider's opinion is that the member's condition cannot be adequately managed without urgent care or services

If a request meets the expedited criteria listed above, an appropriate licensed clinical reviewer who was not involved in initial determination and is not a subordinate of any persons involved in initial decision will render a decision as quickly as the member's health requires. This reviewer will have clinical expertise in the same or a similar specialty, and typically treat the medical condition or perform the procedure.

A member or the provider can request an expedited appeal for all pre-service or continued care services within 30 calendar days of our initial decision or event in question. Neither written confirmation nor the member's written consent is required for the provider to act on the member's behalf and request an expedited appeal.

We immediately initiate the appeals process upon receipt of the expedited request. For requests made by telephone, we acknowledge the request verbally at the time of the initial telephone call from the member, their designated representative or provider. If we receive a written request, we will call the member, their designated representative or provider on the day of receipt to acknowledge the appeal by telephone. At that time, we will inform the complainant that they may immediately contact the Department regarding the appeal.

We will make a decision and provide a written statement on the decision or the pending status of the expedited appeal to both the member and the Department, no later than seventy-two (72) hours from receipt of the request.

Providing prompt notification when denying expedited processing of an appeal

We conduct an initial review of the issue to determine if the issue meets the criteria of an expedited appeal as documented in policy and procedure documents, the website and the Evidence of Coverage. If the issue fails to meet the expedited appeal criteria, we transition it to the standard appeal process and maintain the original received date. We verbally notify the member of the denial of their request for expedited processing. We will follow the verbal notification with a written notification within two (2) calendar days of the decision. The member may file a grievance in response to a denial of expedited resolution.

State Fair Hearing

Members or their designated representative including a provider acting on their behalf with written consent may request a Medi-Cal State Fair Hearing through DSS after the Aetna Better Health of California appeal decision. Additionally, if Aetna Better Health of California fails to adhere to the notice and timing requirements set forth for processing an appeal, the member is deemed to have exhausted the appeals process, and may initiate request for a State Fair Hearing. This request must be completed within one hundred twenty (120) calendar days from the day after the date of the NOA Letter.

Information on how to submit a Medi-Cal State fair hearing is included in Aetna Better Health of California Appeal Decision Letters. Requests should be sent to:

California Department of Social Services
PO Box 9444243, Mail Station 1937
Sacramento, CA 94244-92340

Independent Medical Review

An IMR is defined as a request for independent review to resolve decisions that deny, modify, or delay health care services, that deny reimbursement for urgent or emergency services or that involve experimental or investigational therapies. If a member has already presented the disputed issue for resolution in a Medi-Cal state fair hearing process, the member cannot receive an independent medical review for that same issue.

Members' may request an Independent Medical Review at the same time, in lieu of, or after the Aetna Better Health appeal decision. An IMR may not be requested if a State Fair Hearing has already been requested. They must do so in writing to the California Department of Managed Care within one hundred eighty (180) days of receiving the Appeal Decision Letter at the following address:

Department of Managed Care
HMO Help Center
980 Ninth Street, 5th Floor
Sacramento, CA 95814
Phone: **1-888-466-2219**

The California Department of Managed care will review the request for Independent Medical Review and will send a letter telling the member if they are eligible for Independent Medical Review within seven days. If it is determined that the member qualifies for an Independent Medical Review, the case will be assigned to a state contractor who will perform the review. The state contractor is also known as the Independent Medical Review Organization(IMRO). Eligible means the member has completed the appeal process and their appeal is about medical necessity or the service is experimental or investigational. If the member is eligible and the request is incomplete, the IMRO will send written notification to the member to tell them what is needed to make the request complete.

The IMRO will review the request and render a written decision as expeditiously as the member's health condition requires not exceeding thirty (30) calendar days. For requests related to urgent, emergent care, admission, availability or continued stay when the member has not been discharged the IMRO will render a quick decision. These cases are classified as an expedited IMR. The IMRO will review expedited requests and render a decision within 72 hours of receipt. The IMRO will send written notification of the decision. If the IMRO does not agree with our decision, Aetna Better Health of California will commence the services immediately.

Other Grievance System Rights

Members may also file a complaint with DMHC. If members need assistance in determining their appeal rights, please contact the Member Services Department at **1-855-772-9076**.

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-855-772-9076** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **1-888-466-2219** and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Website www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

Provider Grievance

System Provider Payment Disputes

Network providers may file a payment dispute in writing direct to Aetna Better Health of California to resolve billing, payment and other administrative disputes for any reason including but not limited to: lost or incomplete claim forms

or electronic submissions; requests for additional explanation as to services or treatment rendered by a health care provider; inappropriate or unapproved referrals initiated by the provider; or any other reason for billing disputes. Provider Payment Disputes do not include disputes related to medical necessity.

Providers can file an appeal with Aetna Better Health of California by calling Provider Services Department at **1-855-772-9076**. To file an appeal in writing, providers should write to:

Aetna Better Health of California
Provider Appeals
PO Box 419090
Rancho Cordova, CA 95741

The Provider may also be asked to complete and submit the Dispute Form with any appropriate supporting documentation. The Dispute Form is accessible on: Aetna Better Health of California's website [Provider Dispute Form](#), via fax or by mail. All disputes must have a completed Provider Dispute form including claim number(s) and fax back phone number. Please use the 2nd page of the PDR form ONLY for claims with same issue. PDR forms must be mailed to the following address:

Aetna Better Health of California
10260 Meanley Drive
San Diego, CA 92131

A delay in processing your dispute could be delayed or rejected if form is not attached or information is not complete.

For all disputes, Aetna Better Health of California will notify the Provider of the dispute resolution by fax. Upon receipt of the Dispute, Provider will receive a faxed acknowledgement letter that PDR was received and a disposition letter after review. Providers can appeal the Provider Dispute disposition by filing an appeal. Health Plan must receive the written request within 180 days from the date of the notification. Requests can be sent via email, fax or email

Email: **CAMedi-CalAppealandGrievance@aetna.com**

Fax: **959-888-4487**

Mail: PO Box 81040 5801 Postal Road
Cleveland, OH 44181

Provider Grievance

Both network and out-of-network providers may file a formal grievance in writing directly with Aetna Better Health of California 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 within one hundred eighty (180) calendar days from when they became aware of the issue. Providers can also file a verbal grievance with Aetna Better Health of California when it is related to Aetna Better Health of California staff or contracted vendor behavior by calling **1-855-772-9076**. To file a grievance in writing, providers should write to:

Aetna Better Health of California
Appeal and Grievance Manager:
PO Box 419090
Rancho Cordova, CA 95741

The Appeals and Grievance Manager assumes primary responsibility for coordinating and managing provider grievances, and for disseminating information to the Provider about the status of the grievance.

An acknowledgement letter will be sent within five (5) business days summarizing the grievance and will include instruction on how to:

- Revise the grievance within the timeframe specified in the acknowledgement letter
- Withdraw a grievance at any time until Grievance Committee review

If the grievance requires research or input by another department, the Appeals and Grievance Manager will forward the information to the affected department and coordinate with the affected department to thoroughly research each

grievance using applicable statutory, regulatory, and contractual provisions and Aetna Better Health of California's written policies and procedures, collecting pertinent facts from all parties. The grievance with all research will be presented to the Grievance Committee for decision. The Grievance Committee will include a provider with same or similar specialty if the grievance is related to a clinical issue. The Grievance Committee will consider the additional information and will resolve the grievance.

Aetna Better Health of California will resolve all provider grievances within thirty (30) calendar days of receipt of the grievance and will notify the provider of the resolution within ten (10) calendar days of the decision.

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 California within one hundred eighty (180) calendar days from the Aetna Better Health of California Notice of Action. The expiration date to file an appeal is included in the Notice of Action. All written appeals should be sent to the following:

Aetna Better Health of California
Appeal and Grievance Manager:
PO Box 419090
Rancho Cordova, CA 95741

The Appeals and Grievance Manager assumes primary responsibility for coordinating and managing Provider appeals, and for disseminating information to the Provider about the status of the appeal.

An acknowledgement letter will be sent within five (5) business days summarizing the appeal and will include instruction on how to:

- Revise the appeal within the timeframe specified in the acknowledgement letter
- Withdraw an appeal at any time until Appeal Committee review

The appeal with all research will be presented to the Appeal Committee for decision. The Appeal Committee will include a provider with same or similar specialty. The Appeal Committee will consider the additional information and will issue an appeal decision.

Aetna Better Health of California will inform providers through the Provider Manual and other methods, including periodic provider newsletters, training, provider orientation, the website and by the provider calling their Provider Services Representative about the provider appeal process.

Oversight of the Grievance and Appeal Processes

The Compliance Department has the responsibility for oversight of the Grievance System processes. The Grievance System Manager has overall responsibility for management of the Grievance System processes and reports to the Director of Operations. This includes:

- Documenting individual complaints, grievances and appeals
- Coordinating resolutions
- Maintaining the appeals and grievance database
- Tracking and reviewing complaint, grievance and appeal data for trends in quality of care or other service related issues
- Reporting all data to the Service Improvement Committee (SIC) and Quality Management Oversight Committee (QMOC)

Aetna Better Health of California's grievance and appeals processes are integrated into our quality improvement program. Our Quality Management (QM) responsibility of the grievance system processes includes:

- Review of individual quality of care grievances
- Aggregation and analysis of complaint, grievance and appeal trend data
- Use of the data for quality improvement activities including collaboration with credentialing and recredentialing processes as required

- Identification of opportunities for improvement
- Recommendation and implementation of corrective action plans as needed

The Aetna Better Health of California Grievance System Manager will serve as the primary contact person for the grievance system processes with the Aetna Better Health of California QM Coordinator in the QM Department serving as the back-up contact person. The Member Services Department, in collaboration with the QM Department and Provider Services Department, is responsible for informing and educating members and providers about a member's right to file a grievance, appeal, IMR or Medi-Cal State Fair Hearing and for assisting members in filing a grievance, or appeal throughout the Grievance System.

Members are advised of their grievance and appeal, IMR, Medi-Cal State Fair Hearing rights and processes at the time of enrollment and at least annually thereafter. Providers receive this information in this Manual, during provider orientations, within the provider agreement and on Aetna Better Health of California's website.

Website and Electronic Grievance Submission

Aetna Better Health's Web site is updated as necessary to ensure information is current, including the online form that members can use to file an exempt grievance, grievance or appeal. Aetna Better Health's Web site is designed for easy access by members, and the online grievance system submission procedure:

- Is accessible through the member services portal and is clearly identified as "GRIEVANCE FORM."
- The form is in HTML format and allows the user to enter required information directly into the form.
- All information submitted through this process is processed through a secure server.
- Allows the member to preview and edit the form prior to submitting.
- Includes a current hyperlink to the California Department of Managed Health Care Website.
- Includes a statement in a legible font that is clearly distinguishable from other content on the page and is in a legible size and type, containing the required Department paragraph as noted in the section above entitled "Telephone Numbers and Required Paragraph."

Aetna Better Health also includes the following information on its Internet Website:

- Telephone number that members or provider scan call, during normal business hours, for assistance obtaining mental health benefits coverage information, including the extent to which benefits have been exhausted, in-network provider access information, and claims processing information.
- A link to prescription drug formularies or instructions on how to obtain the formulary.
- A detailed summary that describes the process by which Aetna Better Health reviews and authorizes or approves, modifies, or denies requests for health care services.
- Lists of providers or instructions on how to obtain the provider list.
- A detailed description of how a member may request continuity of care.
- Information concerning the right, and applicable procedure, of a member to request an Independent Medical Review (IMR).

Aetna Better Health ensures the information available to its members on the Website is current by conducting monthly and quarterly reviews and updates. All information provided on Aetna Better Health's website is made available to members in hard copy format upon request.

CHAPTER 17: FRAUD, WASTE, AND ABUSE

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Aetna Better Health of California has an aggressive, proactive fraud, waste, 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, waste or abuse to appropriate State and federal agencies as mandated by California Administrative Code. During the investigation process, the confidentiality of the patient and people referring the potential fraud and abuse case is maintained.

Aetna Better Health of California uses a variety of mechanisms to detect potential fraud, waste, and 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 include audits, review of provider service patterns, hotline reporting, claim review, data validation, and data analysis.

Special Investigations Unit (SIU)

Our Special Investigations Unit (SIU) conducts proactive monitoring to detect potential fraud, waste and abuse, and is responsible to investigate cases of alleged fraud, waste and abuse. With a total staff of approximately 100 individuals, the SIU is comprised of experienced, full-time investigators: field fraud (claims) analysts; a full-time, dedicated information technology organization; and supporting management and administrative staff.

The SIU has a national toll-free fraud hotline for providers who may have questions, seek information, or want to report potential fraud, waste, or abuse. The number is **1-800-338-6361**. The hotline has proven to be an effective tool, and Aetna Better Health of California encourages providers and contractors to use it.

To achieve its program integrity objectives, the SIU has state-of-the-art technology and systems capable of monitoring Aetna's huge volume of claims data across health product lines. To help prevent fraud, it uses advanced business intelligence software to identify providers whose billing, treatment, or member demographic profiles differ significantly from those of their peers. If it identifies a case of suspected fraud, the SIU's Information Technology and investigative professionals collaborate closely both internally with the compliance department and externally with law enforcement as appropriate, to conduct in-depth analyses of case-related data.

Reporting Suspected Fraud and Abuse

Participating providers are required to report to Aetna Better Health of California all cases of suspected fraud, waste and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

Providers can report suspected fraud, waste, or abuse in the following ways:

- By phone to the confidential Aetna Better Health of California Compliance Hotline at **1-855-321-3727**
- By phone to our confidential Special Investigation Unit (SIU) at **1-800-338-6361**

Note: If you provide your contact information, your identity will be kept confidential.

You can also report provider fraud to DHCS, at **1-800-822-6222** or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at **1-800-HHS-TIPS (1-800-447-8477)**.

The California Department of Health Care Services Program Integrity Unit was created to preserve the integrity of the Medicaid program by conducting and coordinating Fraud, Waste, and Abuse control activities for all State agencies responsible for services funded by Medicaid.

A provider's best practice for preventing fraud, waste, and abuse (also applies to laboratories as mandated by 42 C.F.R. 493) is to:

- Develop a compliance program
- Monitor claims for accuracy - verify coding reflects services provided
- Monitor medical records – verify documentation supports services rendered
- Perform regular internal audits
- Establish effective lines of communication with colleagues and members
- Ask about potential compliance issues in exit interviews
- Take action if you identify a problem
- Remember that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim.

Fraud, Waste, and Abuse Defined

- **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.

Examples of Fraud, Waste, and Abuse

Examples of Fraud, Waste, and Abuse include:

- Charging in excess for services or supplier
- Providing medically unnecessary services
- Billing for items or services that should not be paid for by Medicaid
- Billing for services that were never rendered
- Billing for services at a higher rate than is actually justified
- Misrepresenting services resulting in unnecessary cost to Aetna Better Health of California due to improper payments to providers, or overpayments
- Physical or sexual abuse of members

Fraud, Waste, and Abuse can incur risk to providers:

- Participating in illegal remuneration schemes, such as selling prescriptions
- Switching a member's prescription based on illegal inducements rather than based on clinical needs.
- Writing prescriptions for drugs that are not medically necessary, often in mass quantities, and often for individuals that are not patients of a provider
- Theft of a prescriber's Drug Enforcement Agency (DEA) number, prescription pad, or e-prescribing login information
- Falsifying information in order to justify coverage
- Failing to provide medically necessary services
- Offering members a cash payment as an inducement to enroll in a specific plan
- Selecting or denying members based on their illness profile or other discriminating factors.
- Making inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness.

- Altering claim forms, electronic claim records, medical documentation, etc.
- Limiting access to needed services (for example, by not referring a member to an appropriate provider).
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral in exchange for the ordering of diagnostic tests and other services or medical equipment).
- Billing for services not rendered or supplies not provided would include billing for appointments the members fail to keep. Another example is a “multi patient” in which a provider visits a nursing home billing for twenty (20) nursing home visits without furnishing any specific service to the members.
- Double billing such as billing both Aetna Better Health of California and the member, or billing Aetna Better Health of California and another member.
- Misrepresenting the date services were rendered or the identity of the member who received the services.
- Misrepresenting who rendered the service, or billing for a covered service rather than the non-covered service that was rendered.

Fraud, Waste and Abuse can incur risk to members as well:

- Unnecessary procedures may cause injury or death
- Falsely billed procedures create an erroneous record of the member’s medical history.
- Diluted or substituted drugs may render treatment ineffective or expose the member to harmful side effects or drug interactions.
- Prescription narcotics on the black market contribute to drug abuse and addiction.

In addition, member fraud is also reportable and examples include:

- Falsifying identity, eligibility, or medical condition in order to illegally receive the drug benefit
- Attempting to use a member ID card to obtain prescriptions when the member is no longer covered under the drug benefit
- Looping (i.e., arranging for a continuation of services under another members ID)
- Forging and altering prescriptions.
- Doctor shopping (i.e., when a member consults a number of doctors for obtaining multiple prescriptions for narcotic painkillers or other drugs Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.

Elements to a Compliance Plan

An effective Compliance Plan includes seven core elements:

1. **Written Standards of Conduct:** Development and distribution of written policies and procedures that promote Aetna Better Health of California’s commitment to compliance and that address specific areas of potential fraud, waste, and abuse.
2. **Designation of a Compliance Officer:** Designation of an individual and a committee charged with the responsibility and authority of operating and monitoring the compliance program.
3. **Effective Compliance Training:** Development and implementation of regular, effective education, and training.
4. **Internal Monitoring and Auditing:** Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem area.
5. **Disciplinary Mechanisms:** Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded from participating in the Medicaid program.
6. **Effective Lines of Communication:** Between the Compliance Officer and the organization’s employees, managers, and directors and members of the Compliance Committee, as well as related entities.
 - a. Includes a system to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance, will maintaining confidentiality.
 - b. Related entities must report compliance concerns and suspected or actual misconduct involving Aetna Better Health of California.
7. **Procedures for responding to Detected Offenses and Corrective Action:** Policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry.

Relevant Laws

There are several relevant laws that apply to Fraud, Waste, and Abuse:

- The Federal False Claims Act (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional \$5,500 to \$11,000 per false claim. The False Claims Act prohibits, among other things:
 - Knowingly presenting a false or fraudulent claim for payment or approval
 - Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government
 - Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

"Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; 3) acts in reckless disregard of the truth or falsity of the information.

Providers contracted with Aetna Better Health of California must agree to be bound by and comply with all applicable State and federal laws and regulations.

- Anti-Kickback Statute
 - The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
- Self-Referral Prohibition Statute (Stark Law)
 - Prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship, unless an exception applies.
- Red Flag Rule (Identity Theft Protection)
 - Requires "creditors" to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.
- Health Insurance Portability and Accountability Act (HIPAA) requires:
 - Transaction standards
 - Minimum security requirements
 - Minimum privacy protections for protected health information
 - National Provider Identification (NPIs) numbers
- The Federal Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. §§ 3801-3812, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are \$5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.
- Under the Federal Anti-Kickback statute (AKA), codified at 42 U.S.C. § 1320a-7b, it is illegal to knowingly and willfully solicit or receive anything of value directly or indirectly, overtly or covertly, in cash or in kind, in return

for referring an individual or ordering or arranging for any good or service for which payment may be made in whole or in part under a federal health care program, including programs for children and families accessing Aetna Better Health of California services through Medi-Cal.

- Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), Aetna Better Health of California providers will follow federal and State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs, including programs for children and families accessing Aetna Better Health of California services through Medi-Cal.
- The California False Claims Act (CAFCA), Section 12650-12656 of the California Government Code, which was enacted in 1987 intends any office, employee or agent of the state or of a political subdivision to have the ability, authority and resources to pursue civil monetary penalties, liquidating damages, or other remedies to protect the fiscal and programmatic integrity of the medical assistance programs from health care providers and other persons who engage in fraud, misrepresentation, abuse, or other ill practices, as set forth herein, to obtain payments to which these health care providers or persons are not entitled. Cal. Gov't Code §12650.
- Office of the Inspector General (OIG) and General Services Administration (GSA) Exclusion Program Prohibits identified entities and providers excluded by the OIG or GSA from conducting business or receiving payment from any Federal health care program.

Administrative Sanctions

Administrative sanctions can be imposed, as follows:

- Denial or revocation of Medicare or Medicaid provider number application (if applicable)
- Suspension of provider payments
- Being added to the OIG List of Excluded Individuals/Entities database
- License suspension or revocation

Remediation

Remediation may include any or all of the following:

- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
 - Automatic disbarment
 - Prison time

Additional Resources

- www.leginfo.ca.gov/cgi-bin/displaycode?section=gov&group=12001-13000&file=12650-12656
- <https://oag.ca.gov/cfs/falseclaims>

CHAPTER 18: REPORTING OF MEMBER ABUSE, NEGLECT AND COMMUNICABLE DISEASES

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Mandated Reporters

As mandated by state of California, all providers who work or have any contact with an Aetna Better Health of California members, are required as “mandated reporters” to report any suspected incidences of physical abuse (domestic violence), neglect, mistreatment, financial exploitation and any other form of maltreatment of a member to the appropriate state agency.

Children

Providers must report suspected or known child abuse, and neglect to the California Department of Social Services (DSS) (Sacramento **916-875-5437** and San Diego **858-560-2191** or **1-800-344-6000**) or law enforcement agency where the child resides. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child’s welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

Vulnerable Adults

Providers must report suspected or known physical abuse (domestic violence), neglect, maltreatment, and financial exploitation of a vulnerable adult immediately to one of the following State agencies:

- The National Domestic Violence Hotline at **1-800-799-SAFE** (7233)
- Reporting Agencies
 - Ombudsman Toll Free Crisis Line - **1-800-231-4024**
(www.aging.ca.gov/programs/ombudsman_contacts.asp)
 - Bureau of Medi-Cal Fraud and Elder Abuse - **1-800-722-0432**
 - Adult Protective Services – Sacramento County - **916-874-9377**; or San Diego County – **1-800-339-4661**

Reporting Identifying Information

Any provider who suspects that a member may be in need of protective services should contact the appropriate State agencies with the following identifying information:

- Names, birth dates (or approximate ages), race, genders, etc.
- Addresses for all victims and perpetrators, including current location
- Information about family members or caretakers if available
- Specific information about the abusive incident or the circumstances contributing to risk of harm (e.g., when the incident occurred, the extent of the injuries, how the member says it happened, and any other pertinent information)

After reporting the incident, concern, issue, or complaint to the appropriate agency, the provider office must notify Aetna Better Health of California’s Compliance Hotline at **1-855-321-3727**.

Our providers must fully cooperate with the investigating agency and will make related information, records and reports available to the investigating agency unless such disclosure violates the federal Family Educational Rights and Privacy Act (20 U.S.C. § 1232g).

Examinations to Determine Abuse or Neglect

When a State agency notifies Aetna Better Health of California of a potential case of neglect and abuse of a member, our case managers will work with the agency and the Primary Care Provider (PCP) to help the member receive timely physical examinations for determination of abuse or neglect. In addition, Aetna Better Health of California also notifies the appropriate regulatory agency of the report.

Depending on the situation, Aetna Better Health of California case managers will provide member with information about shelters and domestic violence assistance programs along with providing verbal support.

Examples, Behaviors and Signs

Abuse

Examples of Abuse:

- Bruises (old and new)
- Burns or bites
- Pressure ulcers (Bed sores)
- Missing teeth
- Broken Bones / Sprains
- Spotty balding from pulled hair
- Marks from restraints
- Domestic violence

Behavior Indicators of a Child Wary of Adult Contacts:

- Apprehensive when other children cry
- Behavioral extremes
- Aggressiveness
- Withdrawal
- Frightened of parents
- Afraid to go home
- Reports injury by parents

Behaviors of Abusers (Caregiver and /or Family Member):

- Refusal to follow directions
- Speaks for the patient
- Unwelcoming or uncooperative attitude
- Working under the influence
- Aggressive behavior

Neglect

Types of Neglect:

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

Signs of Neglect:

- Malnutrition or dehydration
- Un-kept 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

Financial Exploitation

Examples of Financial Exploitation:

- Caregiver, family member, or professional expresses excessive interest in the amount of money being spent on the member
- Forcing member to give away property or possessions
- Forcing member to change a will or sign over control of assets

Communicable Diseases

Per California Administrative Code Title 17, Section Subchapter, 1, 2500 and Health and safety Code Section 3125. Any and all health care providers with knowledge of a case or suspected case of communicable diseases are expected to report such cases to their local Health Department. Confidential Morbidity Cards (PM 110-11/81), are available from the local Health Department as required in this code. For more information on this subject please refer to the DHCS link below:

- www.cdph.ca.gov/pubsforms/forms/Pages/CD-Report-Forms.aspx
- www.cdph.ca.gov/programs/dcdc/Pages/default.aspx

CHAPTER 19: PHARMACY MANAGEMENT

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Effective January 1, 2022, the Department of Health Care Services (DHCS) transitioned the pharmacy benefit from Medi-Cal managed care plans to Medi-Cal Rx. DHCS utilizes Magellan Rx as their pharmacy benefit management vendor.

Medi-Cal Rx is responsible for the coverage of the following pharmacy benefits when billed by a pharmacy on a pharmacy claim:

- Covered outpatient drugs
- Specific medical supply
- Enteral nutritional products

Medi-Cal Rx Resources

The Contract Drug List (CDL) is a list of drugs that are covered by Medi-Cal Rx. To see the complete CDL and the covered products list, visit <https://medi-calrx.dhcs.ca.gov/home/cdl/>

To see which Medi-Cal Rx covered medications require a prior authorization, visit <https://medicalrx.dhcs.ca.gov/home/cdl/> and choose “Medi-Cal Rx Approved NDC List – Month Year.”

For questions regarding Medi-Cal Rx pharmacy benefits, policies, and procedures, contact the Medi-Cal Rx Customer Service Center at **1-800-977-2273**, available 24 hours per day, 7 days per week, inclusive of holidays and weekends. Or visit Medi-Cal Rx Homepage at <https://medi-calrx.dhcs.ca.gov/home/>

Physician Administered Drugs

Aetna Better Health of California will continue to provide Medi-Cal benefits and support services, including the coverage of physician administered drugs (PADs) under the medical benefit. To learn more about criteria sets used to make clinical medical necessity determinations for PADs, review the Medical Necessity Criteria subsection in Chapter 12. Providers and members have the right to appeal an adverse determination. Refer to Chapter 16 to learn more about the appeals process.

Visit Aetna Better Health of California’s Pharmacy Page for more information:
aetnabetterhealth.com/california/providers/pharmacy-resources.html

CHAPTER 20: FORMS

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The following forms can be found online at [AetnaBetterHealth.com/California](https://www.aetna.com/better-health/california):

- **Consent to Sterilization**
Consent to sterilization must be signed by both the enrollee and the provider performing the sterilization.
- **Acknowledgment of Hysterectomy Information**
An acknowledgment of information provided related to hysterectomy to be signed by both the enrollee and provider.
- **Provider Claims Dispute Form**
To be completed by a provider who needs to file a claim dispute.
- **Pharmacy Coverage Determination Request Form**

CHAPTER 21: PROVIDER'S BILL OF RIGHTS

Each provider who contracts with a Medi-Cal Plan to furnish services to the members will be assured of the following rights:

- A Health Care Professional, acting within the lawful scope of practice, will not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
 - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - Any information the member needs in order to decide among all relevant treatment options.
 - The risks, benefits, and consequences of treatment or non-treatment.
 - The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- To receive information on the Grievance, Appeal and State Fair Hearing procedures.
- To have access to the Medi-Cal Plan's policies and procedures covering the authorization of services.
- To be notified of any decision by the Medi-Cal Plan to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- To challenge, at the request of the Medicaid/CHIP member on their behalf, the denial of coverage of, or payment for, medical assistance.
- The Medi-Cal Plan's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification.

CHAPTER 22: Enhanced Care Management & Community Support Services

Network

- Introduction to CalAIM and ECM/CS (ILOS) programs and State-required/delivered trainings
- ECM/CS “Vetting” Process
 - Certification tool, review & process
 - See policy for additional information to include here
- Aetna network and Community Support (In Lieu of Service ILOS) providers
- CS benefits and eligibility criteria for 14 services
- CS Referral and authorization process
 - ECM services
 - Providers will submit authorization requests to ABHCA’s via email or fax.
 - Community Support Services
 - Providers can submit authorization requests to ABHCA’s via email or fax.
 - Providers can submit authorization requests through the FindHelp (formerly Aunt Bertha Marketplace). *See FindHelp section.*
- Billing (paper or electronic)/claims submission and claims dispute process
 - Providers who can submit claims are expected to continue to submit claims through their existing process.
 - Providers who cannot submit claims will be able to submit invoices to receive payment for ECM / Community Support services.
 - Community Support providers who cannot submit claims will have the option to have FindHelp receive invoices and submit to Aetna’s CA clearinghouse for claims payment.
- Cultural competency
 - *See existing section- Chapter 4 (Page 38)*
- Health literacy information
 - *See existing section-Chapter 4 (Page 38)*
- Record maintenance
 - *See existing section-Chapter 4 (Page 33)*
- Provider and member appeals/grievance procedures
 - *See existing section-Chapter 16 (Page 92)*
- ECM Prior authorization process
 - *See existing authorization section-Chapter 12 (Page 64)*
- Access and availability
 - *See A&A section of provider manual-Chapter 4 (Page 22)*
- Aetna’s Language Line and interpreter information
 - *See existing section-Chapter 2 (Page 15)*
- Available provider services: location and use of provider manual and provider portal
 - *See existing section-Chapter 1 (Page 13)*
- Access to records/sharing records for member transitions
 - *See existing section-Chapter 4 (Page 32)*

CalAIM Enhanced Care Management (ECM) & Community Supports (ILOS)

What is CalAIM – California Advancing and Innovating Medi-Cal

CalAIM is a multi-year initiative led by DHCS that aims to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing delivery system and payment reforms across the program.

CalAIM leverages Medicaid as a tool to help address many of the complex challenges facing California’s most vulnerable residents and takes a person-centered approach that targets social determinants of health and reduces health disparities and inequities.

Whole Person Care (WPC)/Health Homes Program transitioning to ECM/Community Supports January 1, 2021

1. High utilizers
2. Homeless
3. Transitioning from incarceration
4. Individuals at risk for Institutionalization Adults: SMI or SUD
5. Individuals at risk for Institutionalization Children: SMI, SED or SUD
6. Individuals at risk for Institutionalization Eligible for LTC PCP, specialist, group
7. Nursing facility residents who want to transition to the community
8. Children or Youth with complex health needs e.g. CCS, foster care

CalAIM ECM Populations of Focus Timeline

ECM go-live will occur in stages, by Population of Focus.

Populations of Focus	Go-Live Timing
1. Individuals and Families Experiencing Homelessness	January 2022 (WPC/HHP counties);
2. Adult High Utilizers	
3. Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD)	July 2022 (other counties)
4. Incarcerated and Transitioning to the Community	January 2023
5. At Risk for Institutionalization and Eligible for LTC	
6. Nursing Facility Residents Transitioning to the Community	
7. Children / Youth Populations of Focus	July 2023

CalAIM Community Supports

Aetna Better Health of California is offering 14 Community Support services as of January 1, 2022

- | | |
|--|---|
| 1. Housing Transition/Navigation Services | 8. Nursing Facility Transition/Diversion to ALF |
| 2. Housing Deposits | 9. Nursing Facility transition to home |
| 3. Housing Tenancy and Sustaining Services | 10. Personal Care and Homemaker Services |
| 4. Short-Term Post-Hospitalization Housing | 11. Environmental Accessibility Adaptations |
| 5. Recuperative Care (Medical Respite) | 12. Meals / Medically Tailored Meals |
| 6. Respite | 13. Sobering Centers |
| 7. Day Habilitation Programs | 14. Asthma Remediation |

CalAIM ECM Authorizations

Prior Authorization requests may be submitted via either:

- Email: ABHCAEnhancedCareManagement@aetna.com
- **FAX: 860-900-1779**

Service Authorization Decision Timeframes	Turnaround Times
Urgent pre-service approval	Seventy-two (72) hours from receipt of request
Non-urgent pre-service approval	Five (5) business days from receipt of the request
Post-service approval	Thirty (30) calendar days from receipt of the request.

- ECM providers will submit CS (ILOS) service authorizations via fax or email.
- The ECM Provider, Community Support Provider and Member will all receive a copy of the Notice of Action (NOA) letter with the determination (approved or denied)

CalAIM Community Support Authorizations

Prior Authorization requests may be submitted by:

- Secure Email: ABHCAEnhancedCareManagement@AETNA.com
- Fax: **860-900-1779**

The FindHelp Marketplace: <https://aetnacacal-aim.findhelp.com/>

Service Authorization Decision Timeframes	Turnaround Times
Urgent pre-service approval	Seventy-two (72) hours from receipt of request
Non-urgent pre-service approval	Five (5) business days from receipt of the request
Post-service approval	Thirty (30) calendar days from receipt of the request.

Technology and Data Sharing

- Our innovative approach to providing CS(ILOS) allows for a more seamless, ABHCA customized, real-time tracking experience that has not been offered before.
- The FindHelp (Aunt Bertha) Marketplace is customized for ABHCA enabling providers to search for ABHCA contracted CS (ILOS) providers and services in a directory type format.
- Providers are able to submit the CS(ILOS) authorization request to ABHCA through the Findhelp Marketplace.
- Capacity monitoring for ECM and ILOS services,
- Platform for gaps in care
- Quality measure reporting (site reviews)
- Value-based payment—interventions

- Encounter data
- Member eligibility, claims
- Technical assistance in data transfer
- Technology platform use
- Reporting between MCPs and Providers
- Member Level Data Sharing
 - a. ABHCA sends providers the MCP Member Information File (TEL list)
 - i. Decision Needed: Determination for which provider gets which TEL list
 - b. ECM Providers
 - i. ECM Provider Return Transmission File
 - ii. ECM Provider Initial Outreach Tracker File
- Notice of action
 - a. See ECM Authorization section

Community Health Worker (CHW) Preventive Services

Community health worker (CHW) services are preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health. Community health workers may include individuals known by a variety of job titles, including promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals. For more information regarding the Community Health Worker benefit, you can refer to the following website: <https://www.dhcs.ca.gov/community-health-workers>

If you should have any questions about this communication, please contact Aetna Better Health of California at **1-855-772-9076** or email us at [**CaliforniaProviderRelationsDepartment@Aetna.com**](mailto:CaliforniaProviderRelationsDepartment@Aetna.com).

CHAPTER 23: Electronic Visit Verification (EVV)

Section 12006(a) of the 21st Century Cures Act, signed into law on December 13, 2016, added section 1903(l) to the Social Security Act (the Act), which mandates states to require the use of EVV for Medicaid-funded personal care services (PCS) and home health care services (HHCS) for in-home visits by a provider.

State law also requires implementation of EVV in accordance with the Welfare and Institutions Code (WIC), section 14043.51 Assembly Bill 133 (Committee on Budget, Chapter 133, Statutes of 2021) that specifically does the following:

Authorizes the Department of Health Care Services (DHCS) to implement an EVV System as required by federal law, in collaboration with other governmental entities;

Requires providers rendering Medi-Cal services subject to EVV to comply with EVV requirements established by DHCS and partners or be subject to non-compliance actions;

Authorizes DHCS and its partners to implement the EVV System through Provider Bulletins and Letters, such as this one; and Allows DHCS to recover from MCPs any or all Federal Financial Participation lost due to an MCPs non-compliance with the EVV requirements.

EVV is a federally mandated telephone and computer-based application program that electronically verifies in-home service visits. As a result, this program will aid in reducing fraud, waste, and abuse.

The EVV program must verify each type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends.

ABHCA is required to implement EVV for all Medi-Cal PCS and HHCS that are delivered during in-home visits by a provider. This includes, but is not limited to, PCS and HHCS delivered as part of Community-Based Adult Services (CBAS), Whole Child Model and Community Supports – personal care and homemaker services, respite services, day habilitation programs – and all other HHCS programs covered under the contract between DHCS and ABHCA. Implementation of EVV is only required for PCS and HHCS delivered in a member’s home, including visits that begin in the community and end in the home (or vice versa).

DHCS defines a “live-in caregiver” as a caregiver that regularly remains in the recipient’s home for more than 24 hours at a time, during which they are available to provide any of the authorized PCS and HHCS.

The List of EVV Provider Type, Procedure, and Place of Service Codes on the DHCS EVV Website determine which providers will be impacted by EVV requirements.

CHAPTER 24: Proposition 56 Supplemental Payments

The following information outlines what Prop 56 is and how to submit any concerns, issues, or questions regarding Prop 56 to Aetna Better Health of California (ABHCA).

Voters approved the California Healthcare, Research and Prevention Tobacco Tax Act (known as Proposition 56), which increased the excise tax rate on cigarettes and tobacco products back in November, 2016. As a result of this approval, Assembly Bill No. 120 was passed in 2017 to appropriate Proposition 56 funds for specified Department of Health Care Services (DHCS) healthcare expenditures.

DHCS has issued several All Plan Letters (APLs) to govern the distribution of Proposition 56 funds, mainly as supplemental payments to providers and facilities dating back to 2017. Each APL contains specific information regarding covered services, program effective dates, funding amounts, qualification requirements, and guidelines for these payments.

APL 19-013 - Proposition 56 Hyde reimbursement requirements for specified services

APL 19-015 - Proposition 56 directed payments for physician services (supersedes APL 19-006)

APL 19-016 - Proposition 56 directed Payments for developmental screening services

APL 19-018 - Proposition 56 directed payments for adverse childhood experiences screening services

APL 20-014 - Proposition 56 value-based payment program directed payments

APL 22-011 - Proposition 56 directed payments for family planning services (supersedes APL 20-013)

APL 22-021 - Proposition 56 Behavioral Health Integration Incentive Program

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-021.pdf>

Frequently Asked Questions

Who is eligible for Prop 56 Supplemental payments?

Any professional provider who is eligible to bill for the applicable services included in any of the APLs governing Proposition 56 funds is eligible for supplemental payments.

Is anyone excluded from Prop 56 Supplemental payments?

In general, services rendered in the following settings are excluded from Proposition 56 supplemental payments: Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Cost Based Reimbursement Clinics (CBRCs), and Indian Health Setting (IHS).

When are Prop 56 Supplemental payments effective?

The effective dates and periods for Proposition 56 payments vary, depending on the APL governing their distribution.

What is the payment amount for Prop 56 and how will I know which codes to bill for a Prop 56 Supplemental payment?

The eligible (qualified) procedure codes and corresponding supplemental payment amounts vary based on the specific guidelines for each APL.

Who do I contact if I have not received my payment?

A team of Aetna Better Health of California (ABHCA) associates are waiting to hear from you.
Contact Us

Email at **Prop56Inquiries@Aetna.com**