AETNA BETTER HEALTH® OF PENNSYLVANIA
AETNA BETTER HEALTH® KIDS

Provider Newsletter

SUMMER 2017

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New: Opioid Use Disorder resource page

We now have an Opioid Use Disorder (OUD) resource page for providers on our Aetna Better Health of Pennsylvania website.

You can find useful web resources about Opioid Use Disorder and relevant resources such as Aetna Clinical Practice Guidelines related to OUD, substance abuse and addiction services, Centers of Excellence locations and more. You can also find prescription drug take back locations to help members properly dispose of unused medications so they don't get into the wrong hands.

Community Health Workers

Aetna Better Health recognizes the importance of the social determinants of health such as housing, access to food, transportation, income security, neighborhoods and building environment. We utilize Community Health Workers (CHW) to assist members in their needs associated with these factors.

A CHW is:

- A trusted member of the community they serve
- A non-clinical specialist who provides support to Aetna members and connects members to the health care system including providers and community supports

A CHW engages members in the following ways:

- Conducts home visits to assess barriers to healthy living and accessing heath care
- Sets up medical and behavioral health office visits
- Explains the importance of scheduled visits
- Reminds members of scheduled visits multiple times
- Accompanies members to office visits as necessary; participates in office visits as necessary
- Acts as a member advocate
- Arranges for social services (such as utility assistance) and surrounding support services
- Locates members when appointments have been missed, provides resources to assist with meeting with future appointments (transportation)
- Helps boost member morale and sense of self-worth
- Provides members with training in self-management skills
- Provides members with someone they can trust by being reliable, non-judgmental, consistent, open, and accepting
- Serves as a key knowledge source for services and information needed for members to have healthier, more stable lives
- Aids with the service not provided by your facility/ staff. Working in collaboration with one another we may succeed in assisting our communities

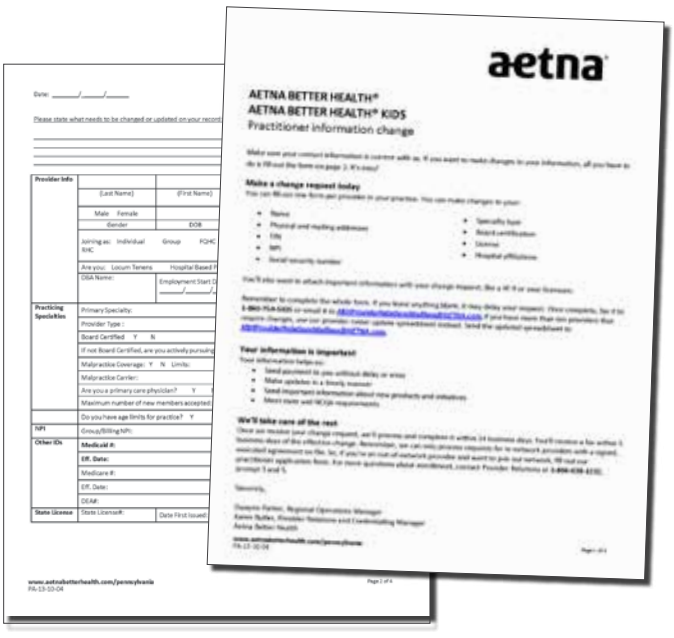
A CHW is **NOT**:

- Able to provide transportation
- Designated as an interpreter for members
- Able to provide medical advice

Is your office contact information current with Aetna Better Health?

Make sure your contact information is current with us. Just fill out the practitioner information change form and fax it to 1-860-754-5435. Or, email it to abhproviderrelationsmailbox@aetna.com.

If you have to make changes to 10+ providers, use our provider roster worksheet. Remember to fill out the entire worksheet. This will allow us to timely update your provider records along with meeting state and NCQA requirements. Once you've updated the spreadsheet, email it to abhproviderrelationsmailbox@aetna.com.



IMPORTANT PROVIDER NOTICE: Required enrollment of ordering, referring and prescribing providers

Effective January 1, 2018, as required by the Affordable Care Act (ACA) and the Department of Human Services (DHS), all providers, including those who order, refer or prescribe items or services for MA or CHIP beneficiaries, must be enrolled with DHS and have a valid PROMISe™ Identification Number (PROMISe ID). DHS uses the National Provider Identification (NPI) number submitted on claims to validate the enrollment of providers in the MA or CHIP Program.

We strongly encourage all MA and CHIP providers who order, refer or prescribe items or services for MA or CHIP beneficiaries and who have not yet registered, to enroll with the state as soon as possible. Many MA and CHIP providers have already done this. If you need to verify if you or an ordering, referring or prescribing provider are enrolled, you can access the DHS online portal.

Note: CHIP Only providers will not be able to validate their status via the online portal until November 2017.

Beginning January 1, 2018, claims will be denied if an ordering, referring or prescribing provider is not enrolled in the MA or CHIP Program.

Please be advised of the following dates:

October 1, 2017 – Aetna Better Health will begin issuing warning notices for claims submitted without an ordering, referring or prescribing provider or with a non-registered ordering, referring or prescribing provider.

January 1, 2018 – Aetna Better Health will deny claims submitted without an ordering, referring or prescribing provider or with a non-registered ordering, referring or prescribing providers.

Timely filing with correct codes ensures timely payment

Aetna Better Health requires providers to submit claims within 180 days from the date of service unless otherwise specified within the provider contract.

- We must receive claim resubmissions no later than 365 days from the date of the Provider Remittance Advice or Explanation of Benefits if the initial submission was within the 180 day time period, whether or not the claim was denied on the first submission.
- You must submit Provider Appeals within 60 days from the date of notification of claim denial, unless otherwise specified within the provider contract.
- **Please note**: An inquiry **does not extend or suspend** the timely filing requirement.
- **Questions about a claim?** Please contact our claims inquiry/claims research (CICR) department at 1-866-638-1232, option 3, then 5 with any questions regarding claims processing.

Prior authorization process

Providers can go to www.aetnabetterhealth.com and submit a request via their web portal access www.aetnabetterhealth.com/pennsylvania/login.

Or, providers can visit the website, click on "For Providers" located at the top of the page, then go to "Quick Links" at the bottom left of the "For Providers" page and click on "Prior Authorization Request Form." Providers should complete the form and fax it to 1-877-363-8120.

Note: This new functionality is for claim resubmissions that include required documentation, not claim corrections or provider appeals.

Check out our secure provider web portal

We are dedicated to providing great service to our providers and our members. That is why our secure HIPAA-compliant web portal is available 24 hours a day. This secure portal supports the functions and access to information that you need to take care of your patients, including:

- **Member eligibility search**
  - Verify current eligibility of one or more member.
- **Panel roster**
  - View the list of members currently assigned to the provider as the PCP.
- **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.
- **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.
  - Search prior authorization requirements by individual or multiple Current Procedural Terminology/ Healthcare Common Procedure Coding System (CPT/HCPCS) codes simultaneously.
  - Review prior authorization requirement by specific procedures or service groups.
  - Receive immediate details as to whether the codes are valid, expired, are a covered benefit, have prior authorization requirements, and any noted prior authorization exception information.
  - Export CPT/HCPS code results and information to Excel.
  - Make certain staff works from the most up-to-date information on current prior authorization requirements.
- **Authorization submissions**
  - Submit an authorization request online. Three types of authorizations are available:
    - Medical Inpatient
    - Outpatient
    - Durable Medical Equipment – Rental
- **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.
- **Provider report management tool**
  - You can now access year-to-date Quality Measurement Reports through the Provider Reports Management Tool, including:
    - HEDIS Gaps in Care Reports
    - Pay-for-Quality Profile Reports
  - NEW: Providers can now enter a claim resubmission form within the secure web portal and attach required documentation to support the claim resubmission.

We are always here to help. Call our Provider Relations Department at 1-866-638-1232, option 3.

Clear Claim Connection

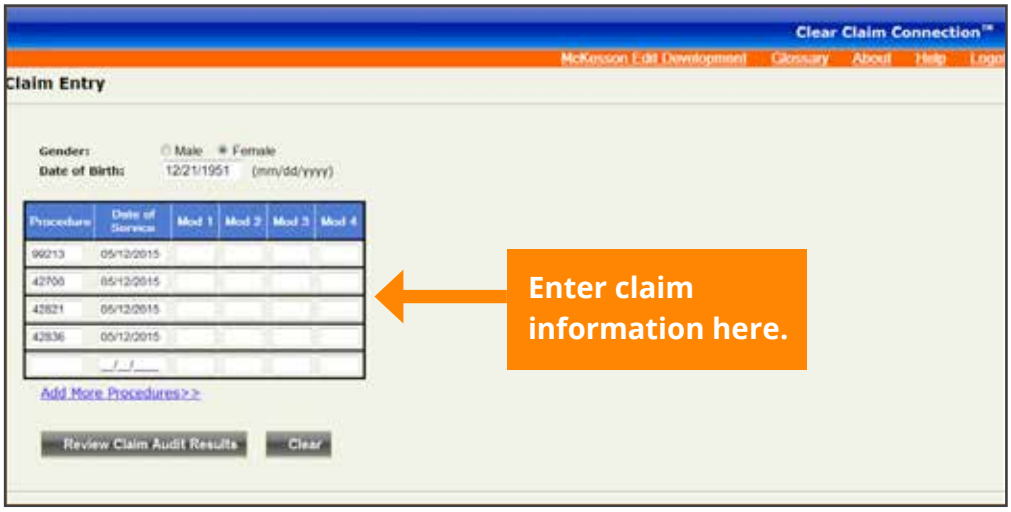
Clear Claim Connection is a high level claim edit tool available on our Provider Portal that allows you to enter procedure codes and determine if a procedure is allowed or disallowed and why if disallowed. When you log in to the Provider Portal, you have access to Clear Claim Connection. Just look for the link.

C3 will only provide the following edits with rationale if applicable:

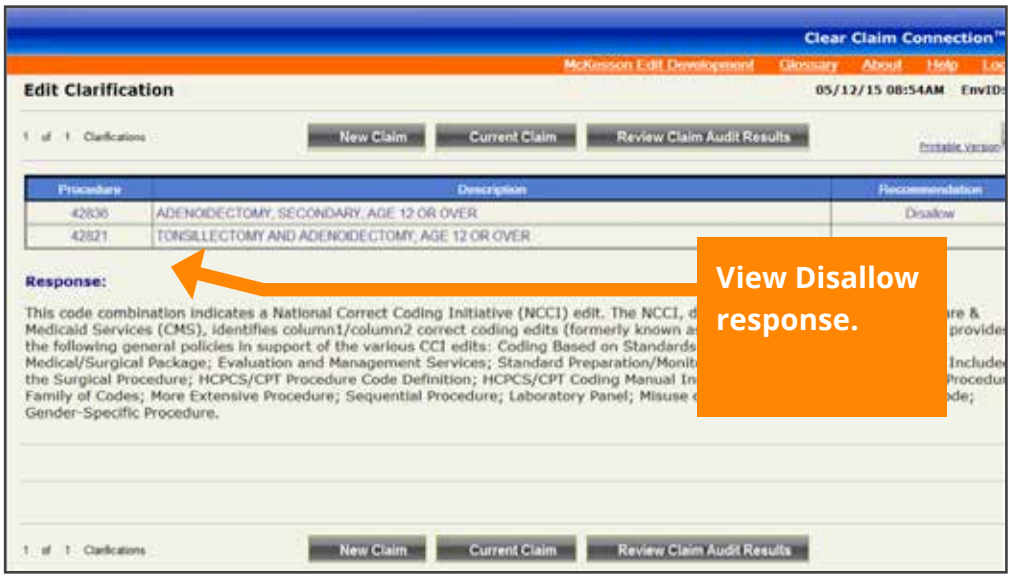
- CCI-Incidental (Federal NCCI CMS)
- CCI-Mutually Exclusive (Federal NCCI CMS)
- ClaimCheck Proprietary Clinical policy edit - Incidental (with edit source noted)
- ClaimCheck Proprietary Clinical policy edit - Mutually Exclusive (with edit source noted)
- Will disallow E/M or PM for pre or post/op if proper modifiers are not present
- Will error if the code is invalid

C3 is not state or health plan specific in its editing. Editing is based on Federal NCCI, AMA, Specialty Society guidelines and clear Industry Clinical standards.

Note: Clear Claim Connection may not give all answers to Aetna Better Health of Pennsylvania customizations or modifications in the Edit Clarifications response.



The Edit Clarification screen appears when you click on Disallow to get the rationale response as shown below:



Claims inquiry/claims research team

Our claims inquiry/claims research team (CICR) will assist you with all claims issues, including:

- Appeals/reconsiderations
- Billing and coding clarification
- Check tracers
- Coordination of benefits (COB) concerns
- Data entry errors
- Claim denials
- Eligibility issues
- Incorrect claim payment
- Pay-to issues
- Prior authorization
- Remittance advice/negative remits
- Claim status
- System issues
- Voided claim issues

Where to send claim payment returns or refunds

If you would like to return or refund payment of a claim, please mail to:

Aetna Better Health of Pennsylvania
Attn: Finance Department
2000 Market St, Suite 850
Philadelphia, PA 19103

If you ever have concerns about your service experience, you can contact one of our highly trained representatives 8 a.m. to 5 p.m. Monday through Friday at 1-866-638-1232, option 3, then 5. For CHIP claims issues, please call 1-800-822-2447. We want to make sure that your experience with CICR exceeds your expectations. If resolution is not reached with a representative, please ask for the assistance of a supervisor.

Provider appeals

Providers may file an appeal with Aetna Better Health if the provider disputes the resolution of a claim denial or adjudication, or services were provided without the proper authorization. **Note:** When submitting the initial prior authorization request, it's important to **submit all clinical information with the initial request**. Providing all clinical information up front will reduce denials related to prior authorization.

Tips for timely review of provider appeals:

- Use the Provider Appeal Form located on our website; go to www.aetnabetterhealth.com/pennsylvania/providers/forms to download and print the form
- Include the claim number on the appeal
- State exactly what is being disputed and why the claim should be paid
- Submit appeals in writing to Aetna Better Health by fax or mail **within 60 days of the provider remittance date**
- Appeals Fax Number: 1-860-754-1757
- Appeals Mailing Address:
  Aetna Better Health of Pennsylvania
  Attn: Provider Appeals
  2000 Market Street, Suite 850
  Philadelphia, PA 19103

Did you know? You can request Code Edit Policy Reconsiderations

Providers can request a reconsideration regarding a code edit policy in situations where the provider's and Aetna Better Health's correct coding policy sources conflict or where they may have a different interpretation of a common correct coding policy source.

All requests for code edit policy reconsiderations must be submitted to Aetna Better Health in writing and should include any source documents and the following:

- A detailed explanation of why you do not agree with Aetna Better Health's current correct coding policy or interpretation
- Include the supporting alternative policy information and the source where it can be found