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AETNA BETTER HEALTH®
AETNA BETTER HEALTH® KIDS

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Table of Contents

Check out our updated and easy to use provider portal 1
Provider Manual 2
ICD-10 information 2
NDC billing requirements for outpatient services 2
Affordable Care Act (ACA) provider revalidation of all provider types 3
PROMISe ID requirements 3
Claims Inquiry /Claims Research Team 3
Provider appeal process 4
New providers joining practice 4
Important CHIP benefit changes 4
Aetna Better Health Mobile App 4
Annual medical records review 5
Member satisfaction 5
Information required for prior authorization, concurrent review, and retrospective review 6
Provider Reports Management Tool now available online 6

Check out our updated and easy to use provider portal

Our enhanced, secure and user-friendly web portal is now available. This HIPAA-compliant portal is available 24 hours a day. It supports the functions and access to information that you need to take care of your patients. Popular features include:

- Single sign-on - One log-in and password allow you to move smoothly through various systems.
- Mobile interface - Enjoy the additional convenience of access through your mobile device.
- Personalized content and services - After log-in, you will find a landing page customized for you.
- Real-time data access - View updates as soon as they are posted.
- Better tracking - Know immediately the status of each claim submission and medical PA request.
- Detailed summaries - Find easy access to details about denied PA requests or claims.
- Enhanced information - Analyze, track and improve services and processes.

For up-to-date information

Review the provider manual and other important information on our website at **www.aetnabetterhealth.com/pennsylvania/providers**.

Continued on page 2

Check out our updated and easy to use provider portal

Continued from page 1

Some of the topics you'll find include:

- Important contact information
- Provider responsibilities
- Member rights and responsibilities
- Quality management program
- Prior authorization process
  - Access to the UM staff
  - Request for criteria
  - Decision making affirmation
- Care management/ disease management programs
- Clinical practice guidelines
- Preventive health guidelines

We're always here to help

To get started or to sign up over the phone you can call provider relations at **1-866-638-1232**.

Provider Manual

The Aetna Better Health provider manual is reviewed annually, at a minimum, and is updated as needed. Your provider manual is a primary information source and an effective guide to your participation with us.

The 2015 provider manual is available on our website at **www.aetnabetterhealth.com/pennsylvania**. Go to the For Providers page and then click Manual on the left side of the page. Please refer to this edition only and discard any previous versions you may have on hand.

Our provider manual is created in a format that allows you to find the information you need quickly. In the Table of Contents, simply click on the desired section or topic to be taken to the appropriate page.

Please take time to review this manual with your staff. Contact your provider relations representative at **1-866-638-1232** with any questions.

ICD-10 information

Providers should not utilize Internal Classification of Diseases, 9th revision (ICD-9) as of September 30, 2015.

The U.S. Department of Health and Human Services released the final ICD-10 compliance deadline of October 1, 2015. We encourage Aetna Better Health providers to access our website and the following materials and resources:

- Internal Classification of Diseases, 10th revision (ICD-10)
- **Centers for Medicare & Medicaid (CMS) ICD-10 Web Site**
- **Road to 10 Web Site**
- **CMS ICD-10 Industry Email Updates**

NDC billing requirements for outpatient services

Aetna Better Health requires providers to submit valid National Drug Code (NDC) numbers in addition to the appropriate HCPC codes for all outpatient services.

With the exception of approved Vaccines for Children vaccines, providers must submit the valid 11 digit NDC number, the unit of measurement qualifier and the quantity when billing an injectable drug. These are essential requirements for both paper and electronic claims and are mandated by the Pennsylvania Department of Human Services for all Medicaid plans.

Any claim billed with invalid or missing NDC codes will be rejected at the claim line level with a reject reason code indicating to resubmit the service line with a valid NDC code. Providers may resubmit a corrected claim with a valid 11-digit NDC code within 365 calendar days from the date of service, as long as the original claim was submitted within the appropriate timeframe.

Please contact provider relations at **1-866-638-1232** with any questions about this notice.

Affordable Care Act (ACA) provider revalidation of all provider types

Important reminder: In accordance with the federally mandated changes resulting from the Affordable Care Act, the Department of Human Services (DHS) must revalidate all providers at least every five years; therefore, all providers (including all associated service locations - 13 digits) who enrolled on or before March 25, 2011 must revalidate their enrollment information no later than March 24, 2016.

This may be accomplished by completing a new enrollment application including all revalidation requirements which may be found on the DHS home page under Provider Enrollment Applications on the right-hand side link: **http://www.dhs.state.pa.us/provider/promise/enrollmentinformation/S_001994**

Please submit your application(s) as soon as possible to ensure they are processed timely with no interruption in your participation with DHS or our partnered managed care plans.

Providers who enrolled after March 25, 2011 will need to revalidate their enrollment information every five (5) years based on their initial date of enrollment and should check their revalidation date by logging into the provider portal for each service location at the following link: **https://promise.dpw.state.pa.us/portal/Default.aspx?alias=promise.dhs.state.pa.us/portal/provider**

For questions about the DHS new enrollment application, please contact DHS provider enrollment at **1-800-537-8862**.

Please contact Aetna Better Health provider relations with any other questions at **1-866-638-1232**.

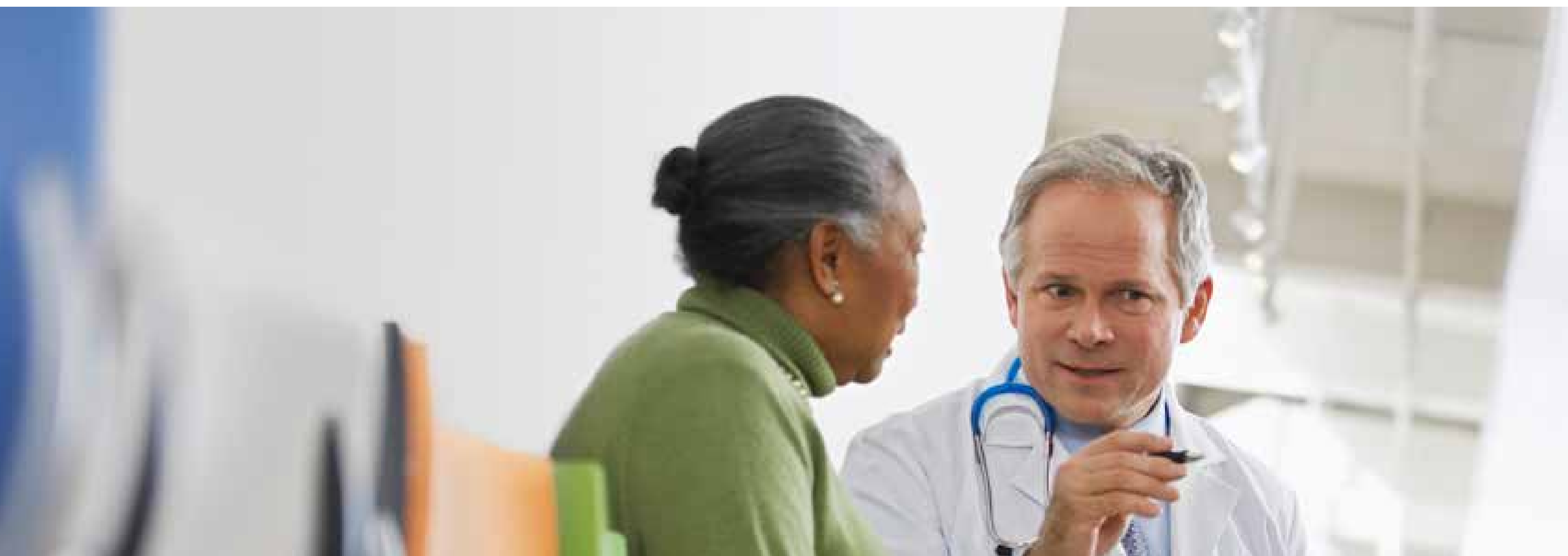
PROMISe ID requirements

Don't forget to report your 13 digit PROMISe ID when submitting claims electronically or by paper. If you need assistance on where to report the 13 digit PROMISe ID, refer to the CMS 1500 manual or contact your clearinghouse vendor. Remember you must have a PROMISe ID prior to seeing an Aetna Better Health member.

If you don't have a PROMISe ID at the time of claim submission, your claim could be rejected or denied. For more information on the PROMISe ID, visit **www.dhs.state.pa.us**.

Claims Inquiry /Claims Research Team

Our Claims Inquiry /Claims Research Team (CI/CR) will assist you with all claims issues, remittance advice questions, reconsiderations, billing and contractual related inquiries. If you ever have concerns about your service experience, you can contact one of our highly trained representatives between 8 a.m. and 5 p.m. Monday through Friday at **1-866-638-1232**. For CHIP claims inquiries, please call **1-800-822-2447**. We want to make sure that your experience with CI/CR exceeds your expectations. If resolution is not reached with a representative, please ask for the assistance of a supervisor.



Provider appeal process

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.

New providers joining practice

If you have a new provider joining your practice, call our provider relations department at **1-866-638-1232** as soon as possible. We'll send you a Provider Application Screening Form to complete and return so we can start the credentialing process.

Or, you can download the form from our website at: **http://www.aetnabetterhealth.com/pennsylvania/assets/pdf/provider/provider-forms/NewIndividualApplication-PA.pdf**.

Important CHIP benefit changes

On August 20, 2015, Governor Tom Wolf announced that all CHIP health insurance plans would provide enhanced benefits. The added benefits are outlined in the Affordable Care Act. These benefits take effect for all children enrolled in CHIP on December 1, 2015.

- To see Governor Wolf's announcement, go to **http://bit.ly/1JeHA1b**
- To access the Pennsylvania Insurance Department's CHIP website go to **http://www.chipcoverspakids.com/**

These changes include removing some historical benefit limits on specific services to ensure Minimal Essential Coverage (MEC) compliance for all CHIP products.

Some categorical benefit changes include:

- Increasing vision services to include low vision items and "add-on" services such as protective coating, when medically necessary
- Adding sealants to the dental benefit package
- Ensuring parity in the number of behavioral health visits without limit
- Increasing outpatient rehabilitation visit limits to 30 per modality per benefit year (PT, OT, ST)
- Dollar limits for autism services have been removed
- Coverage for a home health visit when discharged from the hospital for a delivery or mastectomy

For a full list of changes, please see the updated CHIP member handbook on our website at: **www.aetnabetterhealth.com/pennsylvania**.

There is nothing current Aetna CHIP members need to do to get these benefits

All Aetna CHIP members will automatically receive these enhanced health benefits. Members will not receive new ID cards as the benefits are now MEC required for all free, low and full cost CHIP products by all CHIP contractors in the Commonwealth of Pennsylvania.

Questions?

If Aetna CHIP members have any questions, they can call us at **1-800-822-2447**. We're here Monday to Friday, 8:00 a.m. to 5:00 p.m. TTY users please call **1-800-628-3323**.

As our valued CHIP provider, if you have any questions on these changes please contact Provider Relations at **1-866-638-1232**, option 3.

Aetna Better Health Mobile App

Our members can get on demand access to tools they need to stay healthy with the Aetna Better Health Mobile Application. Members can find a doctor, view or request a Member ID card, change their Primary Care Physician (PCP), see their medical and pharmacy claims, view the member handbook, send us secure messages - and more - at any time, from anywhere.

The mobile app uses the same login ID and password as our website's secure Member Portal. There's no cost for the app and it's easy to use. Members can download the app to their smart phone or tablet from the **Apple App Store** or **Google Play Store**.

Quality Corner

Annual medical records review

On an annual basis, Aetna Better Health randomly selects medical records of its members to review against the Medical Record Keeping Standards that at listed in the Provider Manual (add link). Overall records are found to have complete document of the care provided by practitioners, identification on each page, and follow-up needs including appointment scheduling if needed.

Areas that are found to be below the 85% threshold for compliance include:

1. **Advance Directives**
   Members ages 18 years and older should have documentation related to Advance Directives in the medical record. This can be the actual completed form or documentation of discussion and member response in the progress notes. Additional information on Advance Directives can be found in the **Provider Manual**.
2. **Assessment of member cultural and linguistic needs**
   All members should have documentation in their medical records that providers have assessed their linguistic and cultural needs and provide such as needed, for example translation services (available through Aetna Better Health) and religious needs.

   Patient satisfaction and even positive health outcomes are directly related to good communication between a member and his or her provider. A culturally competent provider effectively communicates with patients and understands their individual concerns. It's incumbent on providers to make sure patients understand their care regimen.

   As part of our cultural competency program we encourage providers to access information on the **Office of Minority Health's web site**. You can also access free online education modules provided by Aetna such as "Closing the Healthcare Gap and Quality Interactions". You can view the catalog of courses **here**.
3. **Communication between providers**
   Member records should also have documentation related to referral communication from specialist; evidence of discharge summary from hospitals, HHA and SNF (if applicable). A copy of letters from specialists or notation of any of the above in the progress notes will be considered evidence for meeting this requirement. This type of communication is critical to ensure that coordination of care for members occurs regularly.

Member satisfaction

Every year Aetna Better Health sends the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) to our members. The survey provides our members the opportunity to share their experience and perceptions on the quality of care and services that are provided by us and our network of providers.

The table below shows our overall results in 2014 in the percentage of members who responded favorable to the categories listed for our Medicaid Child Survey. Our goal is to continually improve. To achieve this, we need your assistance to ensure our members have a positive experience that meets their medical needs and satisfaction with the services they receive. There are several areas for improvement as a result of this survey.

We look forward to working with you to both ensure that our member's needs are met and improve satisfaction with the care and services they receive.

Topic	2013 Results	2014 Results
Rating of Health Plan	79%	76%
Rating of Overall Health	84%	80%
Rating of Personal Doctor	87%	86%
Rating of Specialist	87%	85%
Customer Service	89%	88%
Getting Needed Care	88%	86%
Getting Care Quickly	92%	88%
How Well Doctors Communicate	95%	93%

Information required for prior authorization, concurrent review, and retrospective review

Health care services and items must be medically necessary and provided in an appropriate, effective, timely, and cost efficient manner. Generally, a member's PCP is responsible for initiating and coordinating a request for prior authorization. The admitting or treating practitioner or provider is responsible for making the necessary information available for concurrent review. However, specialists and other participating providers may need to contact the prior authorization or concurrent review department directly to obtain or confirm an authorization.

Providers are responsible for complying with our prior authorization policies and procedures and for getting an authorization number to ensure reimbursement of claims. Information in the prior authorization request or made available for concurrent review must validate the medical necessity for covered care and services, procedures and level of care and medical or therapeutic items.

A request for authorization must also include the following information:

- Current, applicable codes (e.g., Current Procedural Terminology)
- Name, date of birth, sex and identification number of the member
- Primary care or treating provider
- Name, address, phone and fax number and signature, if applicable of the referring provider
- Name, address, phone and fax number of the consulting provider
- Problem/diagnosis, including the ICD-10 code
- Reason for the referral
- Clinical information such as progress notes, consultation reports, a letter of medical necessity, reports of laboratory and imaging studies, and treatment dates, as applicable for the request

Inpatient admission notifications received from the facilities administrative offices, including Admissions, Business, or Finance, satisfies the requirement to notify Aetna Better Health of an admission. These notifications will be processed as an authorization once the required information to validate medical necessity outlined in this section is provided.

Provider Reports Management Tool now available online

We are pleased to inform you that your Quality Measurement Reports are now available online. You may now access year-to-date reports through the Provider Reports Management Tool on our secure web portal at **http://www.aetnabetterhealth.com/pennsylvania/providers/portal**.

Some examples of the types of reports you can access include:

- HEDIS Gaps-in-Care Reports
- Pay-for-Performance Measure Reports

These reports serve as a guide for which Aetna Better Health members need care and where your practice stands regarding Pay-for-Quality incentives for the care you provide.

Be sure you receive credit for the care you provide to Aetna Better Health members

Pay-for-Quality is awarded for care captured administratively through claims submissions.

If you have provided care that we may not have captured due to potential claims or coding issues, please contact Aetna Better Health Provider Relations at **1-866-638-1232**, option 3. You can also directly contact the Quality Translator that has been sending you Gaps-in-Care Reports for assistance.

As a reminder, you can access up-to-date panel lists for your practices on our secure web portal. You can also upload Medical Records for HEDIS Medical Record Review.

Register today

If your practice is not registered for the secure web portal or the Member Care Information portal, just complete and fax the registration form to Provider Relations at **1-860-607-7485**.

The registration form can be found at: **www.aetnabetterhealth.com/pennsylvania/assets/pdf/provider/provider-portals/secure-web-portal-registration-form-PA.pdf**.