AETNA BETTER HEALTH®
AETNA BETTER HEALTH® KIDS

SUMMER 2016

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Provider Revalidation Deadline - July 30, 2016

The deadline is rapidly approaching for Medical Assistance provider enrollment/ revalidation.

The Pennsylvania Department of Human Services (DHS) requires providers to revalidate their **PROMISe ID** and **service locations by July 30, 2016**.

Please be aware that if you are not enrolled or not submitted a revalidation application by July 30, 2016:

- You will not receive payments from Aetna Better Health beginning **September 25, 2016**
- Payments cannot be made retroactively

You can access application and revalidation requirements on the DHS website at **https://provider.enrollment.dpw.state.pa.us**.

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

You've got questions and we have answers - schedule a site visit today

Our provider relations field reps will come to your office to help with questions, review Aetna Better Health processes and procedures, provide training on our tools and applications, provide helpful information for Quality Improvement incentives, and assist you with access to the Special Needs Unit/Case Management opportunities. Contact us today at **1-866-638-1232** to set up an appointment.

PA-16-07-08

Check out our updated and easy to use provider portal

Our secure and user-friendly web portal is available 24 hours a day. This HIPAA-compliant portal 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**.

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, just call provider relations at **1-866-638-1232**.

New providers joining your 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's **Provider Forms page**.

Keeping provider directory information up-to-date

The Centers for Medicare & Medicaid Services (CMS) requires us to contact you at least quarterly to confirm that the information in our provider directory is accurate. This includes:

- Ability to accept new patients
- Street address
- Phone number
- Any other changes that affect availability to patients

If you notify us of any changes, we have 30 days to update our online directory.

For more information, please refer to this **fact sheet**.

The Council for Affordable Quality Healthcare® (CAQH) helps meet this need

CAQH has a unique solution to ensure that directory information is accurate. They developed it with our help and that of other health plans. CAQH's directory confirmation process uses data from your CAQH ProView ™profile. You simply review, update and confirm your information in ProView. Then, CAQH does the rest. They'll share it with all participating health plans that you authorize to receive it. This eliminates the need for every plan in which you participate to contact you for the same directory information.

CAQH will send you this notice, **CAQH provider directory validation invitation e-mail**, which has instructions on how to update your profile. CAQH will call you if you don't reply, so respond promptly.

Is your office 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 update your provider records timely and meet state and NCQA requirements. Once you've updated the spreadsheet, email it to **ABHProviderRelationsMailbox@AETNA.com**.

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
- Appeals must be submitted 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 Complaints Grievance and Appeals 252 Chapman Road, Suite 250 Newark, DE 19702

Billing and claims essentials

ICD-10 Coding Persistency

What is outpatient ICD-10-CM (diagnosis) coding persistency?

Persistency in coding refers to the ongoing identification of members with chronic medical or behavioral health conditions on a CMS-1500 form through the use of coding from one year to the next. The "persistence rate" is the percentage of members coded with the chronic condition in year one, who are also coded for the chronic condition in year two.

Who does persistency of correct outpatient ICD-10-CM coding affect and how?

Provider

- Accurate diagnosis in the chart accomplishes quality and continuity of care goals.
- Improved quality of care standards.
- Improved risk stratification of patients - higher risk scores for members with more comorbidities.
- Avoids office interruptions for clarification of claims information.
- Improves office administrative efficiencies by decreasing unnecessary payer requests for additional information during the prior authorization or clarification of claims information.

Patient

- Better and earlier identification of patients with chronic conditions allow us to employ quality targeted interventions and education with the patient.

Funding from the State and Federal governments is dependent upon documented morbidity of the population. Persistency in risk scores from year to year potentially results in more dollars being available to purchase services for Medicaid patients.

Where are ICD-10-CM codes entered on the CMS-1500 form?

- Paper Claim - Box 21
- Electronic Claim - Loop 2300, Segment HI01-2; HI02-2;HI03-2; HI04-2

When will plan outreach providers to identify gaps in diagnosis coding persistency from year to year?

- Collaborative outreach from Providers Relations, Medical Management & Quality Management to provider offices will occur on a regular basis to discuss best practices for specific chronic conditions, i.e., chronic renal failure, asthma, GERD and certain behavioral health and substance abuse diagnoses, and gain input and feedback from providers on needed education, resources, and/or potential challenges to coding persistency.

Why is it important to code the care that is documented?

- Specificity in diagnosis documentation results in accurate ICD-10-CM coding.
- Documentation that supports the diagnosis has always been important from a quality of care perspective.

Accurate ICD-10-CM coding achieves accuracy in the diagnosis portion of the claim. See the helpful coding facts below.

ICD-10-CM Coding Facts

- Diagnosis codes submitted on claim forms establish the necessity for services performed.
- The codes submitted on the claims are used by outside agencies and organizations to forecast health care trends and needs.
- The provider of services is the only person who has authority to formulate and determine a diagnosis. Non-clinical staff should not choose a diagnosis for a patient, but may accurately convert a narrative description to a diagnosis code, ideally after they've been trained on the proper use of the ICD-10-CM Manual.
- Proper outpatient diagnosis coding requires using the ICD-10-CM Volumes I and II to choose appropriate codes.

NDC billing requirements for outpatient services

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

When billing an injectable drug, providers must submit the valid 11 digit NDC number, the unit of measurement qualifier and the quantity on the claim. 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.

CPT Category II Code Tips

What are CPT II Codes? CPT Category II codes are tracking codes which facilitate data collection for the purposes of performance measurement. Aetna Better Health recognizes CPT II codes when you bill for HEDIS™ performance measures.

How are CPT II Codes developed? The tracking codes are adopted and reviewed by the Performance Measures Advisory Group (PMAG). The PMAG is made up of experts in performance measurement from organizations including the AMA, NCQA, CMS, AHRQ and JCAHO.

Where can I find a list of CPT II Codes? CPT II codes are released annually as part of the full CPT code set and are updated semi-annually in January and July by the AMA. The current listing of CPT II codes can be found on the **AMA website**.

Why should my organization use CPT II Codes? Not only can using CPT II codes ease the administrative burden of chart review for many HEDIS™ performance measures, use of these codes enables organizations to monitor internal performance for key measures throughout the year, rather than once per year as measured by health plans and Pay for Performance.

By identifying opportunities for improvement, interventions can be implemented to improve performance during the service year.

How should my organization bill CPT II Codes? CPT Category II codes are arranged according to the following categories and are comprised of four digits followed by the letter "F".

- Composite Measures 0001F - 0015F
- Patient Management 0500F - 0575F
- Patient History 1000F - 1220F
- Physical Examination 2000F - 2050F
- Diagnostic/Screening Processes/ Results 3006F - 3573F
- Therapeutic, Preventive, or Other Interventions 4000F - 4306F
- Follow-Up or Other Outcomes 5005F - 5100F
- Patient Safety 6005F - 6045F
- Structural Measures 7010F - 7025F

Use eviCore's online services portal for high tech imaging assistance

Aetna Better Health continues to implement quality initiatives to support patient care efforts and improve service. We use eviCore (formerly MedSolutions) to provide utilization management for high tech imaging services.

eviCore's online services portal was created to enable physicians, network facilities, and members to access information they need as they interact with members of the eviCore clinical professional team.

We encourage providers to utilize eviCore's **secure portal** to assist with authorization inquiries and imaging requests.

Go to the website portal at

- Create your account
- Request an imaging study
- Request case studies
- Verify eligibility
- View guidelines and other information
- Update your profile

If you have questions or need additional high tech imaging assistance, please contact:

- eviCore at **1-800-467-6424**
- Aetna Better Health provider relations at **1-866-638-1232**

For more information on the merger of eviCore and MedSolutions, just visit eviCore's web site at **https://www.evicore.com/pages/media.aspx**/.

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 with any questions regarding claims processing.

Claims Inquiry /Claims Research Team

Our Claims Inquiry /Claims Research Team (CI/CR) 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

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***.

RHC and FQHC FAQ

Aetna Better Health's provider relations reps conducted highly productive collaborative meetings with our network Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) this spring and summer. Our mutual efforts resulted in an FQHC / RHC-specific FAQ to help with common billing and reimbursement questions.

You can access the FQHC /RHC-specific FAQ on the For Providers page on our website. We look forward to meeting again with our valued network FQHC and RHC providers during a second round of visits in the fall of 2016.

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**. 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:

- **Advance Directives**
  - Members ages 18 years and older should have documentation in the medical record related to whether or not the individual has executed an advance directive. 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**.
- **Lead Screening:**
  - For Pediatric Members (6 months to 6 years), there should be documentation in the medical record that the practitioner completed a lead screening questionnaire or have documentation that a venous blood lead level that was performed.
  - Lead Screening Questionnaires should assess if the member lives in or regularly visits a house with peeling or chipping paint that was built before 1960 or if that house (built before 1960) has recent, ongoing or planned renovation.
  - Lead Screening Questionnaires should assess if the member lives with someone whose job or hobby involves any exposure to lead.
- **Assessment of member cultural and linguistic needs**
  - All members should have documentation in their medical records that providers have assessed the linguistic and/or cultural needs and provide if needed, for example translation services (available through Aetna Better Health) and religious needs.
  - Patient satisfaction and 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**.
- **Immunization Records:**
  - For pediatric members, there should be an age appropriate immunization record that is up to date and present within the medical record.

Provider Office Hours of Operation Disparity

Aetna Better Health requires network practitioners offer parity with regards to hours of operations to all Aetna Better Health members which are no lead (in number or scope) than the hours of operation offered to non-Medicaid members. Providers are prohibited from discriminating against Aetna Better Health members.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services are federally-mandated services intended to provide preventive health care to children and young adults (under the age of 21 years) at periodic intervals.

All PCPs who provide services to recipients under age 21 must provide comprehensive health care, screening, preventive services and immunizations as outlined in the **provider manual**.

Finally, it's also important that you bill us appropriately for the services rendered. The **Aetna Better Health EPSDT Coding Tool Kit** will assist you in properly billing for EPSDT services.

Credentialing FAQs

What is credentialing?

Aetna Better Health uses the HealthChoices Agreement and current National Committee for Quality Assurance (NCQA) standards for the review, credentialing and re-credentialing of providers.

Credentialing is a systematic process of assessing and reassessing the qualifications and practice history of a practitioner that includes: obtaining, validating and assessing professional information about the practitioner against defined Aetna Participation Criteria or contractual agreements.

This information includes, but is not limited to:

- Review of relevant training and experience
- Board certification (where applicable)
- Registration or licensure to practice in a healthcare field
- Assessment concerning the practitioner's record of professional competence and conduct

It's important to note that contracting is a separate process and is not the same as credentialing.

Who does Aetna Better Health credential and re-credential?

New practitioners (with the exception of the provider types listed below) including practitioners joining an existing participating practice with Aetna Better Health.

Who does Aetna Better Health not credential?

- Delegated provider entities. These provider entities are responsible for their own credentialing.
- P.A.R.E. providers: Pathology, Emergency Medicine, Anesthesiology, Radiology practitioners
- Speech Therapy, Physical Therapy, Occupational Therapy practitioners
- Nurse Practitioners/NPs (not in a PCP role); CRNPs (not in a PCP role)
- Hospital -based, Hospitalist practitioners

ABH does not credential *or* contract with:

- Locum Tenens (substitute physicians)
- Physician Assistants (PAs)

Who must complete the Aetna Better Health practitioner application and OIG form?

All practitioners must complete the Aetna Better Health practitioner application. This is the request to be added or join our network. All Providers except P.A.R.E and delegated providers are required to complete (1) Office of Inspector General (OIG) Form and (1) Aetna Better Health practitioner application.

What is an OIG large group exception?

- If your group has 100 or more practitioners you can complete the disclosure of ownership and controlling interest worksheet (OIG form) yearly for each group NPI
- When submitting the practitioner screening form you do not need to complete the provider and subcontract disclosure of ownership and controlling interest worksheet (OIG form) for the individual provider
- A roster needs to be sent to us with the practitioner screening form adding the new practitioner
- Only providers who submitted an application will be OIG verified, not the entire roster
- If a new provider is joining the group, then a new roster is required including the new provider's name and NPI number

What is the credentialing timeline?

- 60-90 days for new applications
- Up to 60 days for RHC-FQHCs

How can I check status of a credentialing application?

Contact Aetna Better Health Provider Relations by phone or email

- Phone - **1-866-638-1232** and select option #3 and then #5 for Provider Relations
- Email - **ABHProviderRelationsMailbox@aetna.com**