Healthy happens together

Provider Manual

AetnaBetterHealth.com/Pennsylvania

Aetna Better Health® of Pennsylvania
Aetna Better Health® Kids

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Chapter 1

Introduction

Together, we can make a difference.

At Aetna Better Health of Pennsylvania, we are committed to ensuring a positive experience along with providing a mutually beneficial relationship. Supporting our valued providers allows us to work together for the well-being of your patient, our member. Aetna Better Health of Pennsylvania is a managed care organization serving the commonwealth for the HealthChoices managed care program and the Children's Health Insurance Program (CHIP).

The Commonwealth of Pennsylvania Department of Human Services (DHS) offers these programs to Medical Assistance (MA) members and Children's Health Insurance Program (CHIP) members.

Our ability to serve our members well depends on the quality of our provider network. As part of our network, you provide the people of Pennsylvania quality health care and access to medically necessary services. We're grateful for your participation and hope this manual serves as a helpful resource to you and your office staff.

Use this manual as an extension of your participating Provider Agreement, a communication tool and reference guide. While the provider manual contains basic information about the Commonwealth of Pennsylvania Department of Human Services (DHS) and the Centers for Medicare and Medicaid Services (CMS), make sure you fully understand and apply DHS and CMS requirements when administering covered services; refer to **DHS.pa.gov** and **cms.hhs.gov**. You can also find the Commonwealth of Pennsylvania MA Program at **DHS.pa.gov**. Information about the CHIP program is at **chipcoverspakids.com**.

We're in your community. Our Provider Relations representatives are dedicated liaisons who are here to help you. Our community outreach team works with local organizations to build health awareness and connect our members to care. And with a phone call to our support staff, your office receives quick and courteous attention as well.

About Aetna Better Health of Pennsylvania

Aetna Better Health is a wholly owned subsidiary of Aetna Health Holdings LLC, which is a wholly owned subsidiary of Aetna Inc. We combine the financial and administrative strength of Aetna with the depth of Medicaid experience and expertise of our Aetna Medicaid Business Unit. Aetna has more than 150 years of experience in meeting individuals' health care needs.

Aetna brings 30 years of experience managing and serving the full range of Medical Assistance and CHIP beneficiaries. We have served Pennsylvania members since 1993, with the start of CHIP. We received full health plan Commendable accreditation by the National Committee for Quality Assurance (NCQA) in December 2018 for our MA and CHIP lines of business.

Visit **AetnaBetterHealth.com/PA** for more information about us.

About the HealthChoices Program

The HealthChoices Program is Pennsylvania's managed care program for Medical Assistance members. Through Physical Health Managed Care Organizations, MA members get quality medical care and timely access to all appropriate physical health services. This is true whether the services are delivered in an inpatient or an outpatient basis. The DHS Office of Medical Assistance Programs oversees the Physical Health component of the HealthChoices Program,which is outlined in this manual.

This manual pertains to the participation in the HealthChoices Physical Health Program across Pennsylvania, including the Northeast, Northwest, Southeast, Southwest and Lehigh-Capital zones.

The mission of Pennsylvania HealthChoices is:

- To improve access to health care services for MA members
- To improve the quality of health care available to MA members
- To stabilize Pennsylvania's MA spending

About the Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) is a state- and federally funded program offering health insurance to all uninsured children and teens, up to age 19, who are not eligible for or enrolled in Medical Assistance. CHIP is brought to you by Aetna Better Health Kids, and we are committed to providing care to all eligible uninsured children and teens in our service area. Effective December 15, 2015, administration of CHIP was moved from the Pennsylvania Insurance Department to the Department of Human Services.

Through CHIP, children and teens are able to receive high-quality medical care from a wide network of providers. Services include doctor's office visits, prescription drugs, dental and vision care, diagnostic testing and more.

Aetna Better Health Kids offers CHIP coverage in the following Pennsylvania counties:

- Adams
- Berks
- Busks
- Chester
- Cumberland
- Dauphin
- Delaware
- Franklin
- Fulton
- Lancaster
- Lebanon
- Lehigh
- Monroe
- Montgomery
- Northampton
- Perry
- Philadelphia
- York

Aetna Better Health Subcontractors

Dental

SKYGEN USA

skygenusa.com

Authorizations
SKYGEN USA
P.O. Box 628, Milwaukee, WI 53201

Claims
SKYGEN USA
P.O. Box 1352, Milwaukee, WI 53201

Corrected Claims
SKYGEN USA
P.O. Box 1354, Milwaukee, WI 53201

Member Services
Medical Assistance:
1-866-638-1232
CHIP: **1-800-822-2447**

Provider Services
1-800-508-4892
or
1-866-638-1232

SKYGEN USA provides dental services to MA and CHIP members under the Aetna Better Health and Aetna Better Health Kids contracts.

Vision

Superior Vision
superiorvision.com

Mailing and Claims
Superior Vision
939 Elkridge Landing Rd.
Suite 200
Linthicum, MD 21090

Member Services
1-800-428-8789

Provider Services
1-866-819-4298

Superior Vision provides vision services to MA and CHIP members under the Aetna Better Health and Aetna Better Health Kids contracts.

Pharmacy

For questions about pharmacy, call Aetna Better Health MemberServices at **1-866-638-1232**.

Language Line Services (Interpretation Services)

Aetna Better Health provides telephonic interpretive services in more than 175 languages. Personal interpreters can also be arranged in advance. All interpreter services are provided free of charge for Aetna Better Health and Aetna Better Health Kids members. MA or CHIP members can call **1-800-385-4104** for language line services.

Chapter 2

Contact information

We are always responsive to your needs.

This section includes resources to better serve our members, enhance our relationship and increase office efficiency.

Key contact information
Aetna Better Health Administrative Office
Aetna Better Health of Pennsylvania
1425 Union Meeting Road
Blue Bell, PA 19422
1-866-638-1232 (MA)
1-800-822-2447 (CHIP)
AetnaBetterHealth.com/PA

Submit paper claims to:
Aetna Better Health Claims Submissions
P.O. Box 62198
Phoenix, AZ 85082-2198

Aetna Better Health Department	Contact	Hours of Operation (ET) Excluding state holidays
Member Services Eligibility Verification Complaints & Grievances	**1-866-638-1232 (MA)** **1-800-822-2447 (CHIP)**	8 AM - 5 PM, Monday - Friday
Medical prior authorization (MA and CHIP)	**P: 1-866-638-1232** **F: 1-877-363-8120** **IP: 1-877-619-5871** **PDN: 1-877-787-5168**	24 hours a day, 7 days a week
Pharmacy prior authorization (MA and CHIP)	**P: 1-866-638-1232** **F: 1-877-309-8077**	24 hours a day, 7 days a week
Provider Relations (MA and CHIP)	**1-866-638-1232**	8 AM - 5 PM, Monday - Friday
Claim Inquiry Claim Review	**1-866-638-1232**	8 AM - 5 PM, Monday - Friday
Special Needs Unit	**1-855-346-9828**	8 AM - 5 PM, Monday - Friday

Office of Medical Assistance Programs (OMAP) Hotlines

We cooperate with the functions of OMAP Hotlines, which are intended to address clinically related systems issues encountered by members and their advocates or providers. OMAP Hotlines facilitate resolution according to our policies. To contact the HealthChoices OMAP Hotline, call **1-800-426-2090**, 9 AM - 5 PM, Monday - Friday.

Website

Our health plan website, **AetnaBetterHealth.com/PA**, is available 24 hours a day, 7 days a week, for easy access to forms, resources, tools and more. Registered providers can also access our secure web portal via the website or directly at **AetnaBetterHealth.com/PA/providers/portal**. The secure web portal allows Aetna Better Health of Pennsylvania to communicate health care information directly to practitioners and providers. Eligibility and claims information can be accessed via the portal.

Additional information regarding the website and secure web portal is included in Chapter 3: Provider Resources and Responsibilities.

Pennsylvania Department of Human Services

Contact Information/ Help for MA Providers	Contact	Hours of Operation Eastern Standard Time (EST)(Excluding state holidays)
DHS Helpline	**1-800-692-7462**	8:30 AM-4:45 PM, Monday-Friday
DHS Child Line	**1-800-932-0313** TDD: **1-866-872-1677**	24 hours a day, 7 days a week
Behavioral Health	**1-800-433-4459**	7:45 AM-3:45 PM, Monday-Friday
OMAP – HealthChoices Program:Complaint, Grievance and Fair Hearings	**1-800-798-2339**	8:30 AM-4:30 PM, Monday-Friday
Eligibility Verification System (EVS)	**1-800-766-5EVS (5387)**	24 hours a day, 7 days a week
MA Provider Compliance Hotline (formerly Fraud and Abuse Hotline)	**1-866-379-8477**	9 AM-3:30 PM, Monday-Friday
Provider Inquiry Hotline	**1-800-537-8862** Option 4	8 AM-4:30 PM, Monday-Friday
Medical Assistance Provider Enrollment: Applications In Process (Inpatient and Outpatient Providers)	**1-800-537-8862**, Option 1	8:30 AM-12 noon, 1–3:30 PM, Monday-Friday
Medical Assistance ProviderEnrollment Changes	**1-800-537-8862**, Option 1	8 AM-4:30 PM, Monday-Friday
Outpatient Providers Practitioner Unit	**1-800-537-8862**, Option 1	8 AM-4:30 PM, Monday-Friday
Pharmacy Hotline	**1-800-558-4477**, Option 1	8 AM-4:30 PM, Monday-Friday

Behavioral health, drug and alcohol services for Medical Assistance (MA) members

Aetna Better Health MA members receive mental health, drug and alcohol services through Behavioral Health (BH) Managed Care Organizations (MCO) in each county . Refer to the list below to contact the BH-MCO office in the member's county.

Counties	Phone	BH MCO
Philadelphia	**1-888-545-2600**	Community Behavioral Health (CBH)
Adams, Allegheny, Bradford, Berks, Blair, Cameron, Carbon, Centre, Chester, Clarion, Clearfield, Clinton, Columbia, Elk, Erie, Forest, Huntingdon, Jefferson, Juniata, Lackawanna, Luzerne, Lycoming, McKean, Mifflin, Montour, Monroe, Northumberland, Pike, Potter, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Warren, Wayne, Wyoming, York	**1-800-553-7499**	Community Care Behavioral Health Organization (CCBHO)
Bucks, Delaware, Lehigh, Montgomery,Northampton, Cambria	**1-888-207-2911**	Magellan Behavioral Health of Pennsylvania (MBH)
Cumberland, Perry, Dauphin, Lancaster, Lebanon	**1-888-722-8646**	PerformCare
Bedford, Somerset	**1-866-773-7891**	PerformCare
Franklin, Fulton	**1-866-773-7917**	PerformCare
Armstrong, Beaver, Butler, Crawford, Fayette, Greene, Indiana, Lawrence, Mercer, Washington, Westmoreland, Venango	**1-877-615-8503**	Value Behavioral Health

Medical Assistance Transportation Program (MATP) for Medical Assistance (MA) members

Below is a list of MATP contacts by county. You can refer MA members needing assistance with transportation to these local county offices. MA members can use these numbers to obtain information on how to enroll in the MATP. For more information, visit **matp.pa.gov**.

County	Phone
Adams	1-800-632-9063
Allegheny	1-888-547-6287
Armstrong	1-800-468-7771
Beaver	1-800-262-0343
Bedford	1-814-643-9484
Berks	1-800-383-2278
Blair	1-800-458-5552
Bradford	1-800-242-3484
Bucks	1-888-795-0740
Butler	1-866-638-0598
Cambria	1-888-647-4814
Cameron	1-866-282-4968
Carbon	1-800-990-4287
Centre	1-814-355-6807
Chester	1-877-873-8415
Clarion	1-800-672-7116
Clearfield	1-800-822-2610
Clinton	1-800-206-3006
Columbia	1-800-632-9063
Crawford	1-800-210-6226
Cumberland	1-800-632-9063
Dauphin	1-800-309-8905
Delaware	1-866-450-3766
Elk	1-866-282-4968
Erie	1-800-323-5579
Fayette	1-800-321-7433
Forest	1-800-222-1706
Franklin	1-800-632-9063
Fulton	1-800-999-0478
Greene	1-877-360-7433
Huntingdon	1-800-817-3383
Indiana	1-888-526-6060
Jefferson	1-800-648-3381
Juniata	1-800-348-2277

County	Phone
Lackawanna	1-570-963-6482
Lancaster	1-800-892-1122
Lawrence	1-888-252-5104
Lebanon	1-717-273-9328
Lehigh	1-888-253-8333
Luzerne	1-800-679-4135
Lycoming	1-800-222-2468
McKean	1-866-282-4968
Mercer	1-800-570-6222
Mifflin	1-800-348-2277
Monroe	1-888-955-6282
Montgomery	1-215-542-7433
Montour	1-800-632-9063
Northampton	1-888-253-8333
Northumberland	1-800-632-9063
Perry	1-800-632-9063
Philadelphia	1-877-835-7412
Pike	1-866-681-4947
Potter	1-800-800-2560
Schuylkill	1-888-656-0700
Snyder	1-800-632-9063
Somerset	1-800-452-0241
Sullivan	1-800-242-3484
Susquehanna	1-866-278-9332
Tioga	1-800-242-3484
Union	1-800-632-9063
Venango	1-814-432-9767
Warren	1-877-723-9456
Washington	1-800-331-5058
Wayne	1-800-662-0780
Westmoreland	1-800-242-2706
Wyoming	1-866-278-9332
York	1-800-632-9063

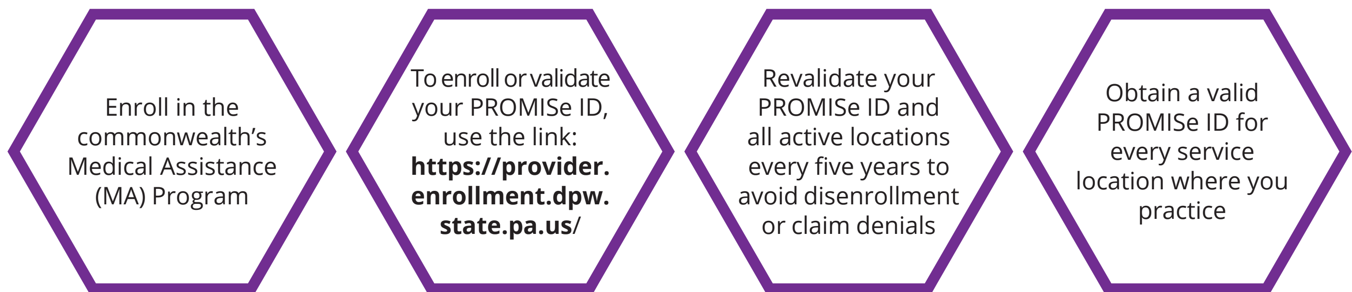
Chapter 3

Provider resources and responsibilities overview

This section outlines general provider responsibilities; additional responsibilities are included throughout this manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws.

Provider enrollment

Providers that render services to Aetna Better Health or Aetna Better Health Kids members, including ordering, rendering and prescribing providers are required comply with the following state-mandated requirements:



Medicaid and CHIP providers who are contracted with Aetna Better Health and rendering services to Medicaid or CHIP beneficiaries, yet not enrolled for all service locations, need to enroll immediately.

Provider responsibilities include, but are not limited to, the responsibilities outlined in the provider contract and in this manual. For more information regarding PROMISe enrollment, please visit the Aetna Better Health or DHS website.

Adherence to the Provider Agreement

Providers are contractually obligated to adhere to and comply with all terms of the Provider Agreement with Aetna Better Health of Pennsylvania, including all requirements in this manual. We may or may not specifically communicate such terms in forms other than the Provider Agreement and this manual. Aetna Better Health and all contracted network providers must comply with all governing federal and state requirements.

Documentation

Providers must document and maintain in the member's medical record all office visits, referrals, contacts, patient education, Advance Directives, family planning counseling, and follow-up with members, including referrals for behavioral health and dental services.

Where applicable and required by regulatory agencies, providers must make all medical records available. Notations regarding follow-up of canceled and missed appointments should also be evident. Records must be signed, dated and legible.

We'll conduct routine audits of medical records to ensure that documentation meets standard requirements.

Providers must supply copies of records within 14 days of the receipt of a request, where practicable and in no event later than the date required by any applicable law, regulatory authority or government agency with jurisdiction over Aetna Better Health's operations (a "Government Sponsor"). Except as required by applicable state or federal law, Aetna Better Health (including Aetna Better Health's authorized designee), Government Sponsors and Aetna Better Health members shall not be required to reimburse providers for expenses related to providing copies of patient records or documents.

Primary care practitioner (PCP) responsibilities

A primary care practitioner (PCP) is a specific physician, physician group or certified registered nurse practitioner (CRNP) operating under the scope of their licensure.

The primary role of the PCP is to help manage the health care of members.

We can assist members in establishing a source of primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective. Every member chooses or is assigned to a PCP. We work with PCPs to ensure members receive timely, medically necessary and appropriate services.

The PCP is the member's initial and most important point of contact regarding health care needs.

The PCP is responsible for:

- Maintaining continuity of care on behalf of the MA or CHIP member
- Locating, coordinating and monitoring other medical care and rehabilitative services
- Supervising, prescribing and providing primary care services

- Providing primary and preventive care
- Acting as the member's advocate by providing, recommending and arranging for care
- Documenting all care rendered in a complete and accurate encounter record that meets or exceeds the DHS data specifications
- Maintaining continuity of each member's health care, including as appropriate, transitioning young adult members from pediatric to adult providers beginning no later than the member's 18th birthday
- Making referrals for specialty care and other medically necessary services both in-and out-of-plan
- Maintaining a current medical record for the member, including documentation of all services provided to the member by the PCP as well as any specialty or referral services
- Using sign language interpreters for those who are deaf or hard of hearing, and oral interpreters for those with limited English proficiency (LEP) when needed by the member. Services are free of charge to the member . This directive was established in the July 2010 State HealthChoices Agreement .

Preventive services

The PCP is responsible for providing appropriate preventive care for eligible members . These preventive services include, but are not limited to:

- Age-appropriate immunizations
- Disease risk assessment
- Age-appropriate physical examinations
- Well-child care
- Adult well-care
- Early and Periodic Screenings, Diagnosis and Treatment (EPSDT/Bright Futures) evaluationsand screenings

You can find preventive health information on our website at **AetnaBetterHealth.com/PA/providers/guidelines**.

Members who are women may:

- Go to any Aetna Better Health contracted obstetrician/gynecologist (OB/GYN) for all women's care services . Neither a referral nor prior authorization is required
- Receive family planning services from an in- or out-of-network provider without a referral or prior authorization

Member assignment to a practice

Upon enrollment, members may choose a PCP for themselves and any other eligible family members. We'll automatically assign a contracted PCP for any member who does not select a PCP within 14 business days of enrollment. If the member is dissatisfied with the auto-selection assignment or wishes to change their PCP for any reason, he or she can choose an alternative participating PCP at any time by calling Member Services at **1-866-638-1232** (MA) or **1-800-822-2447** (CHIP). We'll grant the request and process the PCP change in a timely manner.

We manage each PCP's panel to automatically stop accepting new members after the limit of 1,000 members has been reached. If the PCP/PCP site employs certified registered nurse practitioners/physician assistants, then the provider/provider site will be permitted to add an additional 1,000 members per provider to the panel. We require providers to attest to their panel size annually.

Registered provider portal users can access a list of members assigned to their panel through the Search Panel Roster option via the web portal.

PCPs who wish to close their panel must submit a written request to Provider Relations. Panel closure requests will be reviewed by the plan and a decision will be communicated toyou by your Network Relations Consultant.

A provider can request the change of a member's PCP if the provider is having difficulty getting the member to comply with their care plan or there are other significant conflicts. Call Provider Relations for more information.

Non-adherent members

It's important to manage your patients' care in a way that motivates them to comply with treatment plans and attend scheduled appointments. Make every effort to do this rather than transferring non-adherent patients to another provider. If you have non-adherent patients who aren't responding to reasonable efforts, you can refer them to our Care Management team. Just call us at **1-866-638-1232**.

Maintain accurate provider rosters, service locations and contact information

Network providers should contact their Provider Relations Consultant or Provider Services with changes to their demographic information. Providers may verify their demographic data at any time using the "real-time" provider network directory at **AetnaBetterHealth.com/PA/find-provider**. Requests for changes to address, phone number, or tax ID, or additions and/ or deletions to group practices, must be made through the online the Provider Change Form at **https://medicaidportal.aetna.com/mcainteractiveforms/ProviderForms/ProviderDemographicChangesForm.aspx**.

You can also update us via a paper change form: **AetnaBetterHealth.com/PA/assets/pdf/provider/provider-forms/practitioner-information-change-form-PA2018.pdf**. Change forms can be emailed to **ABHProviderRelationsMailbox@aetna.com** or mailed to:

Aetna Better Health and Aetna Better Health Kids
Attention: Provider Relations
1425 Union Meeting Road
Blue Bell, PA 19422

Access to specialty care

The PCP is responsible for initiating, coordinating and documenting referrals to specialists within Aetna Better Health, the BH-MCO or behavioral health provider and dentists. Members may request a second opinion from providers within the contracted network. If there is not a second provider with the same specialty in the network, members can request a second opinion from a provider out of network at no charge to the member.

When members need a referral to another provider, specialists must coordinate with the provider accordingly. Upon request, you must share records with the appropriate providers and forward at no cost to the plan member or other providers.

Standing referrals

Referrals are not required; however, you may request a standing referral for treatment of a member's disease or condition. If a member needs ongoing care from a specialist, we'll authorize, if medically necessary, a standing referral to the specialist with clinical expertise in treating the member's disease or condition.

Specialists as PCPs

Members may qualify to select a specialist to act as their PCP if they have a disease or condition that is life-threatening, degenerative or disabling. Providers credentialed as specialists and approved to act as PCPs must meet all standards for credentialed PCPs and specialists. The specialist as a PCP must agree to provide or arrange for all primary care and routine preventive care consistent with our preventive care guidelines. They must also provide the specialty medical services consistent with the member's "special need" in accordance with our standards and within the scope of the specialty training and clinical expertise. In order to accommodate the full spectrum of care, the specialist acting as a PCPalso must have admitting privileges at a hospital in our network.

PCPs are responsible for initiating and coordinating member referrals for medically necessary services beyond the scope of their contract of practice. In addition, PCPs and specialists must monitor the progress of the referred member's care, and specialists must see that members are returned to the PCP's care as soon as medically appropriate.

School-based services

School districts often provide an array of medically necessary health services performed by licensed professionals that may include, but are not limited to, immunizations, well-child care and screening examinations. Our provider relations team or special needs unit can assist you in finding services in your area.

Behavioral health referrals for Medical Assistance (MA) members

We provide a full range of covered physical health services for MA members who have behavioral health needs and/or are admitted to non-hospital residential detoxification, rehabilitation and halfway house facilities for drug/alcohol dependence/addiction.

Services currently covered under the above-mentioned facilities per diem payment are not provided by us, nor are we responsible for providing Behavioral Health Services for MA members.

Behavioral health is managed through the Behavioral Health–Managed Care Organizations (BH-MCOs), serving the HealthChoices program. Providers should arrange for medically necessary Behavioral Health services for members by appropriate referrals to a HealthChoices BH-MCO, in accordance with the specifications of the Provider Agreement. We will cover ambulance and emergency department services only for medically necessary behavioral health services. We realize all outpatient pharmacy services, except those otherwise assigned, are the payment responsibility of the member's BH-MCO. **The only exception is that the BH-MCO is responsible for the payment of methadone when used in the treatment of substance abuse disorders and when prescribed and dispensed by BH-MCO service providers.**

Members should be referred to the BH-MCO for the following benefits/services:

- Inpatient psychiatric hospital services, except when provided in a state mental hospital
- Inpatient drug and alcohol detoxification
- Psychiatric partial hospitalization services
- Inpatient drug and alcohol rehabilitation
- Non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol dependence/addiction
- Emergency department evaluations for voluntary and involuntary commitments pursuant to the Mental Health Procedures Act of 1976, 50 P.S. 7101 et seq
- Psychiatric outpatient clinic services, licensed psychologist and psychiatrist services
- Behavioral health rehabilitation services (BHRS) for individuals under the age of 21 with psychiatric, substance abuse or mental retardation disorders
- Residential treatment services for individuals under the age of 21 whether treatment is provided in facilities with or without Joint Commission for the Accreditation for Healthcare Organizations (JCAHO) accreditation
- Outpatient drug and alcohol services, including methadone maintenance clinics
- Methadone when used to treat narcotic/opioid dependency and dispensed by an in-plan drug and alcohol services provider
- Laboratory studies ordered by behavioral health physicians and clozapine support services
- Crisis intervention with in-home capability
- Family-based mental health services for individuals under the age of 21
- Targeted mental health care management (intensive care management and resource coordination)

Along with mental health, drug and alcohol and behavioral services that are covered, supplemental mental health and drug and alcohol services may be made available pursuant to coordination agreements between the BH-MCO and the county mental health, mental retardation and drug and alcohol authorities. You can find more information on the BH-MCOs that serve each county on the DHS website at **HealthChoices.pa.gov/providers/about/behavioral/index.htm**.

Behavioral health services for CHIP members

CHIP members are eligible for behavioral health services through Aetna Better Health Kids . The provider is responsible for arranging medically necessary Behavioral Health Services by appropriate referrals to a participating behavioral health provider for CHIP members, in accordance with the specifications of the Provider Agreement.

Some members diagnosed with severe mental illness or severe emotional disturbance (e .g ., schizophrenia or autism spectrum disorder) that significantly affects a child's behavioral health may be eligible for a broader range of services. They may also have different benefit limitations. Call Member Services at **1-800-822-2447** if you have questions about your patient's eligibility for certain mental health services or benefit limits.

CHIP covers inpatient, non-hospital residential, partial hospital, intensive outpatient and routine outpatient treatment for behavioral health.

- Except in the case of an emergency, Behavioral Health Services must be provided by participating providers and facilities, unless the use of a non-participating provider or facility is preauthorized
- A referral from a PCP is not required to see a participating provider. A member (14 years of age or older) or a parent or guardian may self-refer

If your patient needs self-referral assistance, needs help finding a participating provider in their area, has difficulty scheduling an appointment with a participating provider or has questions about behavioral health benefits, call Aetna Better Health Kids Member Services at **1-800-822-2447**. This number is also listed on your patient's Aetna Better Health Kids ID card.

Self-referrals / direct access

Members can access care without a referral from the PCP:

- Specialists
- Vision exams
- Dental care (if eligible)
- Women's health care services including gynecological and obstetrical providers andpreventive health care such as mammograms and Pap tests
- First visit with a chiropractor in accordance with the process set forth in Medical Assistance Bulletin 18-08-01
- First visit with a physical therapist in accordance with the amended Physical Therapy Act (63 P.S. 1301 et seq.)
- Emergency services
- Routine family planning services
- Routine and preventive services

To self-refer, the member must receive the self-referred services from a network provider. Family planning services do not require prior authorization or referral. Members may access family planning services from any qualified provider. Family planning services include, but are not limited to:

- Health education
- Diagnostic screens, biopsies, cauterizations, cultures and assessments
- Breast and cervical cancer screening services
- Counseling necessary to make an informed choice about contraceptive methods
- Contraceptive supplies such as oral birth control pills, diaphragms, foams, creams, jellies and condoms (male and female)
- Norplant, injectables, intrauterine devices and other family planning procedures
- Long-acting reversible contraceptive services (LARC)
- Pregnancy testing

Members have direct access to OB/GYN services. They also have the right to select their own OB/GYN provider, which includes nurse midwives in our network. Members can receive maternity and gynecological care without prior approval from a PCP. Care includes:

- Selection of a provider to give an annual well-woman gynecological visit
- Primary and preventive gynecology care
- Pap smear and referrals for diagnostic testing related to maternity and gynecological care and medically necessary follow-up care
- Perinatal and postpartum maternity care

In situations where a new (and pregnant) member already receives care from an out-of-network OB/GYN specialist at the time of enrollment, the member can continue to receive services from that specialist throughout the pregnancy and postpartum care related to the delivery.

For additional services a member may receive through Fee-for-Service, please refer to page 62: Medicaid home- and community-based waiver programs.

Appointment standards and follow-up

We work with providers to reach out to members concerning appointments for medically necessary care, preventive care and scheduled screenings and examinations. Contracted providers are responsible for adhering to the appointment availability standards. Providers must monitor the adequacy of their appointment processes and reduce unnecessary emergency department visits.

Condition	Members	Provider Types	Standards
Emergency	All	PCP or specialist	Members must be seen immediately or referred to an emergency facility
Behavioral health emergency	CHIP	PCP or specialist	Immediately seen or referred to emergency room
Urgent	All	PCP or specialist	Appointments must be scheduled within 24 hours
Behavioral health non-life threatening	CHIP	PCP or specialist	Appointments must be scheduled within6 hours
Behavioral urgent – no immediate danger	CHIP	PCP or specialist	Appointments must be scheduled within 48 hours
Routine (physical and CHIP behavioral)	All	PCP	Appointments must be scheduled within 10 business days wait time less than 30 minutes
		Specialist: – Dentist – Dermatology – Orthopedic surgery – Otolaryngology – Pediatric allergy and immunology – Pediatric endocrinology – Pediatric gastroenterology – Pediatric general surgery – Pediatric hematology – Pediatric infectious disease – Pediatric nephrology – Pediatric neurology – Pediatric oncology – Pediatric pulmonology – Pediatric rehab medicine – Pediatric rheumatology – Pediatric urology	Appointments must be scheduled within 15 business days
		All other specialty pediatric general surgery	Appointments must be scheduled within 10 business days
Health assessment	All	PCP	Appointments must be scheduled within3 weeks of enrollment
General physical examination	All	PCP	Appointments must be scheduled within3 weeks of enrollment
First physical examination	All	PCP	Appointments must be scheduled within3 weeks of enrollment
Initial appointment	HIV/AIDS members	PCP or specialist	Appointments must be scheduled within 7 days of enrollment unless the member is already in active care with a PCP or specialist
	SSI members	PCP or specialist	Appointments must be scheduled within 45 days of enrollment unless the member is already in active care with a PCP or specialist

Condition	Members	Provider Types	Standards
Initial prenatal care appointment	Pregnant members	OB/GYN or certified nurse midwife	
	First trimester		Appointments must be scheduled within 10 business days of the member being identified as pregnant
	Second trimester		Appointments must be scheduled 5 business days of member being identified
	Third trimester		Appointments must be scheduled 4 business days of being identified
	High-risk pregnancy		Appointments must be scheduled within 24 hours of identification or immediatelyif an emergency exists
EPSDT/ Bright Futures screens	All under the age of 21	PCP	Appointments must be scheduled within 45 days of enrollment unless the child is already under the care of a PCP and current with screens

Hours of operation / appointment availability

Aetna Better Health requires that providers' hours of operation offered to MA members be no less than those offered to commercial members. Appointment availability standards are located on pages 18-19.

Our appointment availability standards reflect minimum requirements. We routinely monitor providers for compliance with these standards . Noncompliance may result in the initiation of a corrective action plan or further corrective actions.

PCP waiting times

Waiting time standards for PCPs require that members, on average, should not wait in a PCP office for more than 30 minutes for a routine care appointment. Under certain emergent circumstances – for example, if a physician encounters an unanticipated urgent visit or treatsa member with a difficult medical need – the waiting time may be extended to one hour.

These access and appointment standards are physician contractual requirements. We monitor compliance with appointment and waiting time standards . We will work with providers to ensure that they meet these standards.

Appointment notification and follow-up

The PCP, dentist or specialist must conduct affirmative outreach to a member when that member misses an appointment. Providers must make three outreach attempts, taking the member's language and literacy capabilities into consideration when making the outreach attempt. At least one attempt must be a follow-up telephone call.

You must record the date and type of outreach attempt in the member's medical record.

Communication with the member may include, but is not limited to:

- Written attempts
- Telephone calls
- Home visits

Examinations to determine abuse or neglect

When the County Children and Youth Agency system notifies us of a potential case of child neglect and/or abuse of a MA or CHIP member, we work with the Agency and the PCP to ensure that the member receives timely physical examinations for the abuse or neglect, in accordance with the Child Protective Services Law, 23 Pa. C.S. 6301 et seq. and department regulations. If the PCP determines that the member needs a mental health assessment, the PCP must inform the member or the County Children Youth Agency representative of how to access mental health services. They must also coordinate access to these services, when necessary.

In addition to conducting physical examinations, providers are legally required to proactively report suspected abuse and/or neglect of MA or CHIP members. Providers can report abuse to the DHS Child Line at **1-800-932-0313**, **TDD: 1-866-872-1677**.

The Child Line accepts calls from the public and professional sources 24 hours a day, 7 days a week. The Child Line also provides information, counseling and referral services for families and children to ensure the safety and well-being of the children of Pennsylvania.

Professionals who have reasonable cause to suspect that a child has been abused are required to file a report. The individual may remain anonymous. Each call to the Child Line is answered by a trained intake specialist who will interview the caller to determine the most appropriate course of action.

Actions include:

- Forwarding a report to a county agency for investigation as child abuse or general protective services
- Forwarding a report directly to law enforcement officials
- Referring the caller to local social services (such as counseling, financial aid and legal services)

For more information on how to help children and families, visit the Child Welfare Services section of the DHS website at **keepkidssafe.pa.gov**.

Americans with Disabilities Act (ADA)

Title III of the ADA mandates that public accommodations, such as a physician's office, be accessible to those with disabilities. The provisions of the ADA protect qualified individuals with a disability from:

- Exclusion from participation in the benefits of services, programs or activities of a public entity
- Denial of the benefits of services, programs or activities of a public entity
- Discrimination by any such entity

Physicians should ensure that their offices are as accessible as possible to persons with disabilities.

They should also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. We offer sign language and over-the-phone interpreter services at no cost to the provider or the member.

Call Provider Relations at **1-866-638-1232** for more information.

Member education

Providers are responsible for educating members about:

- Their unique health care needs, health status, medical care or treatment options including any alternative treatment that may be self-administered
- The importance of physical examinations
- Potential treatment options, side effects, management of symptoms, disease prevention and the importance of regular health maintenance
- The member's right to choose the final course of action among clinically acceptable options
- How to access emergency and urgent care providers

Urgent care / emergency care

Urgent care

We are focused on reducing unnecessary emergency department visits. As such, we continually educate our members that their health care needs are best served by their personal physician – their medical home. We remind them about the importance of scheduling an annual visit with their PCP and that their PCP is someone who gets to know them and their specific situation well. We acknowledge the quality health care services our providers give our members during regular office hours. However, the incidence of members seeking non-emergency services after hours continues to grow, often resulting in medically unnecessary trips to hospital emergency rooms.

Aetna Better Health encourages members to seek treatment at urgent care centers, after-hours and walk-in centers in our network as an alternative to using an emergency department. These facilities can provide treatment for most mild to moderately acute conditions. They're typically open when practitioners' offices are closed or when members cannot wait for an appointment.

You should make your patients aware of the proper utilization of the PCP office and urgent care facilities outside of your office hours in lieu of hospital emergency departments.

You can refer patients to an urgent care facility in our network if you cannot see thepatient immediately.

You can find a complete list of centers on our website at **AetnaBetterHealth.com/PA**.

In addition to our own network of urgent care centers, we have written policies and procedures requiring PCPs to offer after-hours care or on-call arrangements with qualified providers 24 hours a day, 7 days a week. This helps ensure that members with emergency or urgent care needs can receive timely treatment. Our policies and procedures detail how providers and members can make contact to receive instructions for treatment.

Providers offering after-hours care are not permitted to sign off to the emergency department or to use an answering machine in lieu of a live response.

Emergency care

If a member requires emergency services, they should immediately be sent to the nearest emergency department or urgent care center . Members can go to the nearest emergency department or urgent care without prior authorization.

Post-stabilization services

Aetna Better Health covers post-stabilization services under the following circumstances without prior authorization, whether or not the services are provided by a network provider:

- The post-stabilization services were administered to maintain the member's stabilized condition within one hour of the provider's request for pre-approval of further post-stabilization services
- The post-stabilization services were not pre-approved because Aetna Better Health did not respond to the provider's request for pre-approval of these post-stabilization services within one hour of the request
- The post-stabilization services were not pre-approved because the provider could not reach Aetna Better Health to request pre-approval for the post-stabilization services

- Aetna Better Health and the treating physician cannot reach an agreement concerning the member's care and an Aetna Better Health physician is not available for consultation. In this situation, we will give the treating physician the opportunity to consult with an Aetna Better Health physician and the treating physician may continue with care of the patient until an Aetna Better Health physician is reached or one of the criteria applicable to termination of Aetna Better Health's financial responsibility described below is met

Aetna Better Health's financial responsibility for post-stabilization services without pre-approval ends when:

- A network physician with privileges at the treating hospital assumes responsibility for the member's care
- A network physician assumes responsibility for the member's care through transfer
- Aetna Better Health and the treating physician reach an agreement concerning the member's care
- The member is discharged
- The practitioner/provider is required to notify Aetna Better Health within 24 hours of the emergency admission to inpatient status in accordance with plan requirements

Provider administrative responsibilities

Enrollment with the Pennsylvania Department of Human Services (DHS)
In order to participate with Aetna Better Health, providers must first enroll with the DHS and have a valid Medicaid (PROMISe) ID. To be eligible to enroll:

- Practitioners in Pennsylvania must be licensed and currently registered by the appropriate state agency
- Out-of-state practitioners must be licensed and currently registered by the appropriate agency in their state, and they must provide documentation that they participate in that state's Medicaid program
- All other providers must be approved, licensed, issued a permit or certified by the appropriate state agency and, if applicable, certified under Medicare

To enroll, providers must complete a base provider enrollment form and submit any applicable addenda documents dependent on the provider type. To access enrollment forms and to find other information about how to register with the commonwealth, visit **provider/promise/enrollmentinformation/S_001994**.

The Affordable Care Act (ACA) requires states to revalidate the enrollment of Medicaid providers every five years. Aetna Better Health follows DHS requirements that participating providers revalidate their PROMISe ID and service locations every five years. Failure to complete the revalidation process will result in nonpayment of claims and possible termination with Aetna Better Health.

Provider screening of employees and contractors against exclusion databases In accordance with the requirement stated in 42 CFR §455.436 and MAB #99-11-05, providers must screen employees against exclusion databases. Providers should:

- Develop policies and procedures for screening of all employees and contractors (both individuals and entities)
  - At time of hire or contracting
  - On an ongoing, monthly basis
- Determine if they have been excluded from participation in federal health care programs, using the following databases:
  - Pennsylvania Medicheck List
  - List of Excluded Individuals/Entities (LEIE)
  - Excluded Parties List System (EPLS)
  - National Plan and Provider Enumeration System (NPPES)
  - Social Security Administration's Death Master File (SSA)

If an employee is discovered to be excluded, immediately self-report to the Bureau of Program Integrity.

Member eligibility verification

The provider is responsible for verifying a member's current enrollment status before providing care by:

- Understanding that we will not reimburse for services provided to patients who are not enrolled with Aetna Better Health
- Using members' MA identification ACCESS cards to obtain online eligibility information from the Eligibility Verification System (EVS) Calling Member Services at **1-866-638-1232** or by accessing our secure provider portal at **AetnaBetterHealth.com/PA** to verify members

Refer to Chapter 5: Eligibility and enrollment for further details regarding eligibility verification. Providers are responsible for complying with all administrative procedures.

Prior authorization for services and referrals

A PCP or an independently licensed health care professional who participates in the MA Program must request prior authorization for certain medically necessary services. Unauthorized services will not be reimbursed. Please note that authorization is not a guarantee of payment. Call your Provider Relations Representative for further information. All out-of-network services must go through Prior Authorization.

Providers are strongly encouraged to submit prior authorization requests via the secure web portal . Prior authorization requests can also be submitted by fax. Routine prior authorization requests will not be accepted by telephone.

You can find a current list of services that require prior authorization via our secure provider web portal by clicking on the "Prior Authorization" tab at **AetnaBetterHealth.com/PA/providers/guidelines**.

Practitioner and provider requirements

Generally, a member's PCP or treating practitioner/provider is responsible for initiating and coordinating a request for authorization; however, specialists and other practitioners/providers who use our secure web portal may need to contact the Prior Authorization Department directly to obtain or confirm a prior authorization.

The requesting practitioner or provider is responsible for complying with prior authorization requirements, policies and request procedures along with obtaining an authorization number to facilitate reimbursement of claims

A prior authorization request must include the following:

- Current, applicable codes:
  - Current Procedural Terminology (CPT)
  - International Classification of Diseases, 10th Edition (ICD-10)
  - Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure CodingSystem (HCPCS) codes
  - National Drug Code (NDC)
- Name, date of birth, sex and identification number of the member
- Primary care practitioner or treating practitioner's name, address, phone and fax number
- Name, address, phone and fax number and signature, if applicable, of the referring care provider or practitioner
- Name, address, phone and fax number of the consulting provider or practitioner
- 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.

Coordination of benefits

Providers must adhere to all contract and regulatory cost-sharing guidelines . When a member has other health insurance such as Medicare, a Medicare HMO or a commercial carrier, we're the "payer of last resort ." It is critical that you identify any other available insurance coverage for the patient and bill the other insurance as primary.

In the case of third-party liability, we'll coordinate payment of benefits and pay all Clean Claims for prenatal or preventive pediatric care (including EPSDT/Bright Futures services to children). We'll also pay Clean Claims for services to children having medical coverage under a Title IV-D child support order. This is true as long as we're notified by the Department of Human Services of such support orders or we become aware of such orders. We'll then seek reimbursement from liable third parties. We will not cost avoid the aforementioned claims with the exception of hospital delivery claims. Your contract with us contains guidelines for these situations.

Medical records request

We can request medical records from the provider when researching complaints, grievances and requests for a DHS Fair Hearing or addressing quality of care issues. It's important that you respond to these requests promptly. You can act on behalf of a member with written consent. Refer to Chapter 14: Member complaints, grievances and DHS Fair Hearings for more information about member complaints, grievances and requests for a DHS Fair Hearings.

Health care providers must supply copies of records within 14 days of the receipt of a request, where practicable and in no event later than the date required by any applicable law, regulatory authority or government agency with jurisdiction over our operations (a "Government Sponsor"). Except as required by applicable state or federal law, Aetna Better Health (including Aetna Better Health's authorized designee), Government Sponsors and Aetna Better Health members shall not be required to reimburse health care providers for expenses related to providing copies of patient records or documents.

Submitting medical records

When submitting medical records solicited by Aetna Better Health of Pennsylvania, please include a cover sheet with the following information:

- Provider information (NPI or provider ID)
- Patient information (name, DOB, health plan identification number)
- Applicable claim information (claim number and date of service)

The medical records can be submitted via:

- Secure web portal accessible via our website, or
- Mail to Aetna Better Health, P.O. Box 62198, Phoenix, AZ 85082-2198

For information on submitting medical records and supporting documentation via the secure web portal, please review the step-by-step guide for adding attachments on our website under Portal (secure web portal).

Our Provider Relations team is also available to assist. Please call **1-866-638-1232**.

Compliance with federal regulations

You must comply with regulatory requirements under Title 55, Chapter 1101 of the Pennsylvania Public Welfare Code. To access the most current regulatory requirements, review the Medical Assistance Manual, Chapter 1101 (General Provisions) online at **pacode.com/secure/data/055/055toc.html**.

All providers contracting with Aetna Better Health must adhere to all federal and state rules and regulations. To access more information about the commonwealth's regulations, guides and handbooks, visit the provider information section of the DHS's website at **www.dhs.pa.gov/docs/For-Providers/Pages/default.aspx**.

If you want a hard copy of these regulatory requirements, call Provider Relations at **1-866-638-1232**. To ensure that you have the most updated version of these regulations, visit the DHS website.

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. Culture competency is also the ability to translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members should receive covered services regardless of race, ethnicity, national origin, religion, gender, age, gender identification, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English.

We expect contracted providers to treat all members with dignity and respect as required by federal law.

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color andnational origin in programs and activities receiving federal financial assistance, such as Medicaid.

Cultural competency training

We've developed effective provider education programs that:

- Encourage respect for diversity.
- Foster skills that facilitate communication within different cultural groups.
- Explain the relationship between cultural competency and health outcomes.

These programs provide information related to our members' diverse backgrounds. Theyalso address the cultural, racial and linguistic challenges members face in navigating the various components of our health care system.

We have also developed and implemented methods and techniques that are useful for both the member and provider in responding to these challenges.

You can directly contact our Special Needs Unit at **1-855-346-9828** to discuss diversity practices. We'll help you respond to the diverse needs of our members by providing training and information through our Quality Practice Liaisons or Network Relations Consultants.

Our Provider Liaisons schedule regular visits to in-network provider offices to discuss various topics, including cultural competency and the specific needs of our members.

In addition, we promote and encourage regularly scheduled and ad hoc interaction between Medical Management and our network providers. These interactions present a valuable opportunity for our Quality Practice Liaisons to discuss and help resolve specific cultural, racial or linguistic challenges that may arise.

Most importantly, to the extent possible, we strive to meet member needs by developing and maintaining a provider network that mirrors the racial, ethnic and linguistic composition of our members.

Provider education on cultural competency is required. Our Network Relations Consultants will conduct initial cultural competency training during provider orientation meetings. In addition, providers are encouraged to access the U.S. Department of Health and Human Services website course series online. This course is designed to help you:

- Improve the quality of health care services provided to diverse populations
- Gain more awareness of your own cultural beliefs and be more responsive to those of your patients

- Develop changed beliefs and positive attitudes that can translate into better health care delivery

To access the online cultural competency course, please visit **https://thinkculturalhealth.hhs.gov/education**.

To increase health literacy, the National Patient Safety Foundation created the Ask Me 3™ Program. Aetna Better Health of Pennsylvania supports the Ask Me 3 Program, believing it to be an effective tool to improve health communication between members and providers.

Limited English proficiency and alternate methods of communication

Our policies conform to the federal government's limited English proficiency (LEP) guidelines. These guidelines state that programs and activities normally provided in English must be accessible to LEP persons at no cost. Services must be provided in a culturally effective manner to all members, including those:

- With LEP or reading skills
- With diverse cultural and ethnic backgrounds
- Who are deaf or hard of hearing
- Who are homeless
- With physical and mental disabilities

To ensure members' privacy, you must not interview members about medical or financial issues within hearing range of other patients.

Compliance with federal and state requirements

We make certain that LEP members and members who are deaf or hard of hearing have access to health care and benefits by providing a range of language assistance services at no cost to the member or the provider. We offer translation and interpreter services including American Sign Language to providers and members free of charge.

We strongly encourage using professional interpreters, rather than family or friends, as the member may wish to keep their state of health and treatment plan private. In addition, using a family member or friend doesn't ensure an accurate translation and could lead to multiple office visits.

We offer interpretation services to MA and CHIP members through the Language Line®. The Language Line employs trained and qualified professionals who are well versed in medical terminology. They provide telephonic interpretation in over 175 languages. You can make arrangements in advance for personal interpreters.

Call **1-866-638-1232** to learn more about these services. In addition, we have bilingual staff to assist LEP members. Member materials, such as the member handbook, are available in English and Spanish . Members can also request materials in another language or format.

You can use Language Line services in the following scenarios:

- If a member requests interpretation services, Member Services representatives will assist the member via a three-way call to the Language Line to communicate in the member's native language
- For outgoing calls, Member Services staff dials the Language Line and uses an interactive voice response system to conference with a member and the interpreter
- For face-to-face meetings, our staff (e.g., Care Managers) can conference in an interpreter to communicate with a member in their home or another location
- When you need interpreter services and cannot access them from your office, call us to connect with a Language Line interpreter

Upon member request, we'll make all written materials accessible to visually or hearing impaired members, including:
- Braille
- Audiotapes
- Large print
- CD or DVD
- Sign language interpreters
- TTY services or Pennsylvania Telecommunication Relay Service at **711**. We include appropriate instructions on all materials about how to access or receive assistance with accessing desired materials in an alternate format

Refer to Medical Assistance Bulletin 991711 (effective 8/11/2017) regarding limited English proficiency requirements. The bulletin lists the requirements for providers in order to be compliant with the federal and state regulations, including the 1557 tag line.

HIPAA and confidentiality

HIPAA Notice of Privacy Practices

We maintain strict privacy and confidentiality standards for all medical records and member health care information, according to federal and state standards. You can access up-to-date Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices on our website at **AetnaBetterHealth.com/PA**.

This includes explanations of members' rights to access, amend and request confidential communication of request privacy protection of, restrict use and disclosure of and receive an accounting of disclosures of protected health information (PHI).

Confidentiality requirements

You must comply with all federal, state and local laws and regulations governing the confidentiality of medical information. This includes all laws and regulations pertaining to, but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements.

You’re also contractually required to safeguard and maintain the confidentiality of data that addresses medical records and confidential provider and member information, whether oral or written in any form or medium.

The HIPAA Privacy Rule applies to all “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). “Individually identifiable health 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
- Information that identifies the individual or for which there is a reasonable basis to believeit can be used to identify the individual
- Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security number)

The Privacy Rule 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.

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.

Release of data to third parties requires advance written approval from the Department of Human Services, 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.

Member privacy rights

Our privacy policy assures that all 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 our 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 our 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 laws:

- Make a privacy complaint
- Receive a copy of all or part of their 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

The member or member's authorized representative must submit a privacy request through our Member Services Department. Members can call Member Services at **1-866-638-1232** (**PA Relay: 711**). 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, members or a member's representative must submit requests to us in writing.

Privacy process requirements
Our processes for responding to member privacy requests include components for the following:

Verification
If the requester is the member, we'll verify the member's identity. Verification examples include asking for:

- The last four digits of member's Social Security number
- Member's address
- Member's date of birth

If the requester is not the member, we require the member to complete an Authorization for Use or Disclosure form to verify the requester's authority to obtain the member's information. If the requester identifies him/herself as a member's authorized representative, we require a health care Power of Attorney (POA) or comparable document for a representative to act on behalf of the member.

These materials can be obtained by calling Member Services at **1-866-638-1232 (PA Relay: 711)**.

Review, disposition and response

Our review of privacy requests complies with applicable federal, state and local laws and regulations and applicable contractual requirements, including those that govern use and disclosure of PHI. Responses to privacy requests conform to guidelines prescribed by HIPAA, including response time standards. They'll also include a notice of administrative charges, if any, for granting the request.

Use and disclosure guidelines

We're required to use and disclose only the minimum amount of information necessary to accommodate the request or carry out the intended purpose.

Limitations

A privacy request may be subject to specific limitations or restrictions as required by law. Limitations to a privacy request made include the following conditions:

- We don't maintain the records containing the PHI
- The requester is not the member and we're unable to verify his/her identity or authority to act as the member's authorized representative
- The documents requested are not part of the designated record set (e .g ., credentialing information)
- Access to the information may endanger the life or physical safety of or otherwise cause harm to the member or another person
- We're not required by law to honor the particular request (e .g ., accounting for certain disclosures)
- Accommodating the request would place excessive demands on us or our time and resources

Provider Relations and Support

Claims Inquiry & Claims Research (CICR) team

The CICR team can assist you with claim related questions and concerns. Their enhanced broad service model includes, but is not limited to calls related to:

- Billing or contractual-related questions
- Claim status inquiries (note: this function is also available via the secure web portal)
- Handling claim adjustment requests
- Stop payments or other check related inquiries
- Coordination of benefits (COB) claim issues

The CICR staff is available to assist 8 AM-5 PM, Monday-Friday. Just call **1-866-638-1232**.

Provider Relations representatives

Our Provider Experience department has dedicated liaisons who are here to help you . We want you to have a positive experience with Aetna Better Health. Our provider representativeswill work closely with you to ensure that our relationship is healthy and productive.

Network Relations Consultants

Aetna Better Health assigns every participating provider a Network Relations Consultant by territory. Your Network Consultant serves as a liaison between you and the health plan and will be your single point of contact for services such as:

- Visiting your practice
- Training your staff on Aetna Better Health policies and procedures
- Providing ongoing education resources such as the secure provider portal and Provider Manual
- Resolving operational issues to improve health care delivery
- Being available to answer your questions

They'll answer questions and assist you in meeting requirements and obtaining necessary information. You can also find your provider relations contact information on our website at **AetnaBetterHealth.com/PA/providers**.

Additionally, our Quality Practice Liaisons serve as a valuable resource concerning quality matters. More specific information regarding their role can be found in the Quality Management section of this manual starting on page 113.

For further information, call the Provider Relations Department at **1-866-638-1232**.

Provider Relations technology:

- Secure provider portal
- Administrative functions: Claims submission electronic data interchange (EDI), electronic funds transfer (EFT), electronic remittance advice (ERA)

Provider training and education

We provide a variety of training opportunities for network providers, including, but not limited to:

- Orientation sessions
- Distribution of written materials through mailings and on our website
- Ongoing site visits
- Regularly scheduled provider training forums and meetings
- In-person training sessions at provider offices
- WebEx training sessions for providers
- Annual updates to the Provider Manual

Provider orientation

We provide initial orientation for newly contracted providers within one month after joiningour network . We conduct the orientation either through group sessions or during visits to individual provider offices, clinics or group practice locations. Sessions cover such topics as:

- Covered benefits along with member and provider responsibilities
- Cultural competency

- Provider tools, such as the Provider Manual, website and newsletters
- Process for checking eligibility
- The role of the PCP and appropriate use of the emergency department
- Provider responsibilities for compliance with the Americans with Disabilities Act and how to access health plan interpretation and sign language services
- Methods used to update providers on program and health plan changes
- The role of Care Managers and related activities
- Reporting requirements, including encounter data submission requirements
- Medical records documentation requirements
- The provider complaint, grievance and appeals process
- Medical Management processes, including:
  - Referrals to specialists and out-of-network providers
  - Prior authorization
  - Care and Disease Management
  - Pharmacy drug list
  - Evidence-based clinical guidelines
- Appointment availability standards, including wait times and after-hours availability
- Pay-for-performance opportunities and supporting tools, such as provider profiles
- Members' rights and responsibilities, including the right to file a grievance, complaint or request a DHS Fair Hearing and how a provider can assist members in this process
- Member resources (e .g ., Language Line, community resources)
- Claims payment, including the availability of electronic funds transfer (EFT)
- Coordination of benefits
- Provider responsibility for compliance with commonwealth and federal laws
- Contact information for provider relations and other departments

Site visits

A Provider Representative will contact a new provider within the first 90 days to conduct an initial site visit as well as provide initial new provider orientation.

Following the initial site visit, our provider relations staff may conduct scheduled or unscheduled site visits to assess physical location, office hours, adherence to regulatory requirements, provide training or to conduct joint discussions with you and your office staff.

Provider Education Resources

Visit our website to access Provider Experience Educational Resources to help you learn more about important processes, procedures and educational tools that will assist you and your staff in your roles. Information includes, but is not limited to:

- Billing and claim Information
- PROMISe billing requirements

- Complaints, appeals and grievances
- Early Periodic Screening Diagnosis and Treatment (EPSDT/Bright Futures)
- Pharmacy information
- Program initiatives
- Provider reference material
- Webinars and forums

Provider webinars and forums

We conduct provider webinars and forums for continued education, including:

- Individualized provider training on select topics (e.g., website navigation)
- Group training sessions on select topics (e.g., claims coding, member benefits health forum)
- HEDIS Improvement webinars
- Provider enrollment process webinar
- Provider portal (e.g., authorizations, claims and remittance search)

Ongoing education and communications

We annually update this Provider Manual, which serves as a primary resource for educating new and existing network providers about our policies and procedures. We also notify providers of important revisions through newsletters, provider bulletins, fax blasts, and regularly scheduled and ad hoc communications with our staff and on our website.

Secure web portal

The secure web portal is a web-based platform that allows us to communicate member health care 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 members
- Application Submission:
  - Submit online provider credentialing applications. Applications can also be submitted via email or fax
- 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 codes are valid, expired, a covered benefit, have prior authorization requirements and any noted prior authorization exception information
  - Run data reports and export results and information to Excel
  - Ensure staff accesses the most up-to-date information on current prior authorization requirements
  - Submit email inquiries to the Provider Relations staff

- Submit authorizations: Submit an authorization request on-line. All nonparticipating providers must receive prior authorization for any treatment. These types of authorizations are available:
  - Medical inpatient services including surgical and non-surgical, rehabilitation and hospice
  - Outpatient surgery
  - Home-based services including hospice
  - Therapy
  - Durable medical equipment: rental
  - Non-par providers must receive prior authorization for all treatment
- Pennsylvania 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.

Member Care Information

This secure, online portal gives you the ability to complete the Obstetrical Needs Assessment Form (ONAF) online. You can also access:

- A real-time listing of your patients
- Information on your practice
- Secure email capability with Care Managers

You can access the Secure Web Portal Navigation Guide located on our website for additional information.

Our Provider Relations representatives are also available to assist you. Just call **1-866-638-1232**.

Provider Network Management

Our Network Management staff negotiates contracts with hospitals, physicians, ancillary and other provider types to ensure a broad range of network providers to accommodate our member's health care needs.

Network Managers collaborate with the Utilization Management Department in negotiating rates for non-participating providers and facilities when services have been determined medically necessary and are approved by the health plan for Single Case Agreements. They also work with Network Relations Consultants to answer questions about participating provider contracts.

Provider termination

Suspended, disbarred from services

We follow termination procedures as set forth in the Provider Agreement. We receive notice from DHS if a participating provider is suspended or terminated from participation in the Medicaid or Medicare Programs. Upon notification, we must immediately act to terminate the provider from participation.

Terminations for loss of licensure and criminal convictions must coincide with the MA effective date of the action.

Termination without cause

Provider Agreements may be terminated by either Party via prior written notice given to the other Party with at least 90 calendar days' notice. In addition to the foregoing, the physician may terminate this Agreement in accordance with the provisions of Section 5.1 of the Provider Agreement.

Termination for breach of contract

The Provider Agreement may be terminated at any time by either party, upon at least 60 calendar days prior written notice of such termination to the other party upon material default or substantial breach by such party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within 60 calendar days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such 60-calendar-day period, any termination pursuant to the Provider Agreement Termination Provision will be ineffective for the period reasonably necessary to cure such 60-calendar-day period.

Chapter 4

Credentialing overview

Provider credentialing overview

We use the Pennsylvania HealthChoices Agreement, the CHIP Policy and Procedure Manual and current National Committee for Quality Assurance (NCQA) standards for the review, credentialing and recredentialing of providers. We also use the Council for Affordable Quality Healthcare (CAQH®) Universal Credentialing Data Source for all provider types. The Universal Credentialing Data Source was developed by America's leading health plans collaborating through CAQH. The Universal Credentialing Data Source is the leading industry-wide service to address the credentialing application process.

The Universal Credentialing Data Source program allows practitioners 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 the health plans and hospitals participating in the CAQH effort. Health plans and hospitals designated by the practitioners obtain the application information directly from the database, eliminating the need to have multiple organizations contacting the practitioner for the same standard information. Practitioners update their information on a quarterly basis to ensure data is maintained in a constant state of readiness. CAQH gathers and stores detailed data from more than 600,000 practitioners nationwide.

Practitioners may not treat members until they become credentialed.

Initial credentialing individual practitioners

Initial credentialing is the entry point for practitioners to begin the contract process with the health plan. New practitioners (with the exception of hospital-based providers), including practitioners joining an existing participating practice with Aetna Better Health, must complete the credentialing process and be approved by the Credentialing Committee.

Recredentialing individual practitioners

We recredential practitioners on a regular basis (every 36 months based on state regulations) to ensure they continue to meet health plan standards of care along with meeting legislative/regulatory and accrediting bodies (NCQA and Utilization Review Accreditation Commission) requirements (as applicable to the health plan). Termination of the provider contract can occurif a provider misses the 36-month timeframe for recredentialing.

Facilities recredentialing

As a prerequisite for participation or continued participation in our network, all applicants must be contracted under a facility agreement and satisfy applicable assessment standards. Prior to participation in the network and every three years thereafter, Aetna Better Health Credentialing will confirm that each organizational provider meets assessment requirements.

Ongoing monitoring

Ongoing Monitoring consists of monitoring practitioner and or provider sanctions or loss of license to help manage potential risk of substandard care to our members.

Provider credentialing process

1. As a participant with the CAQH) we utilize the web based CAQH uniform provider application. If the provider doesn't have a complete CAQH application, online registration is required. Please visit **www.caqh.org** and enroll through the Enroll Hub link on the right side of the page.
2. Once the registration is complete, create a personal ID and password to ensure the privacy and accuracy of your confidential information.
3. Utilize your ID and password to access the secured website to complete the online application. You can request a paper copy of the application by calling CAQH. If a CAQH number already exists, it must be active to move forward with the credentialing process.
4. When you identify your provider type and state(s) of practice, the system automatically leads you through the application. Some fields may be pre-populated from information provided by health care organizations and/or hospitals with which you are affiliated.
5. The system allows you to complete the application over time.
6. Once the application is complete, a system audit is conducted to identify errors and/or omissions.
7. Once the corrections are made, you'll review and attest to the accuracy of the information.
8. Fax the requested supporting documents to the designated secure site.
9. The application is complete ONLY when ALL supporting documents are received AND you have attested to the accuracy of information .
10. The credentialing process at Aetna Better Health will begin once the CAQH application is complete.
11. You can access and submit the provider credentialing online application on our website under "Join Our Network" Online Application Form.
12. Alternatively, a paper application can be completed. When you complete the application in full, you can fax your application to **1-800-754-5435** or send your scanned application to **MedicaidAetnaProviderRelations@aetna.com**.
13. We will review your application for accuracy and completeness.
14. Once a clean application is received, an acknowledgment email notification will be sent within 10 calendar days.
15. If your application is incomplete an email notification will be sent within 10 days.
16. If your application is still undergoing the credentialing process 30 days after receipt of a clean application, a second notification will be sent.
17. You will be notified of your credentialing status within 60 days of receipt of the clean application.

All providers must comply with the state-mandated requirements to enroll and revalidate their PROMISe ID and all active and current service locations every five years. Providers who do not complete the revalidation process every five years may have their provider participation disenrolled and their claims denied. You must have an active PROMISe ID in order to complete the credentialing process.

Recredentialing

1. A notification will be sent via email or fax every 36 months to re-attest to the accuracy of your information and to fax updated supporting documents, if applicable.
2. Failure to re-attest or provide updated documents in a timely manner may negatively impact your three-year recredentialing cycle . This may result in termination from our network.

Please fax all completed documents to Aetna Better Health at **1-800-754-5435**. Or mail to:

Aetna Better Health, Attn: Provider Relations
1425 Union Meeting Road
Blue Bell, PA 19422

Credentialing decision notification

Once all information and supporting documents have been verified, the credentialing files are presented for committee decision. We notify all applicants of initial credentialing decisions and recredentialing denials.

Between credentialing cycles

If participation requirements, such as unrestricted DEA or state-mandated CDS certification, are not met, we'll notify you in writing, via certified mail, that your participation with Aetna Better Health is being terminated in accordance with the specific terms identified from the Agreement.

If you respond within 30 calendar days of the date of the notice correcting any factual discrepancies or correctable deficiencies, the Chief Medical Officer or designee has the discretion to overturn the determination.

If your license isn't current or has been encumbered (e .g ., license status of probation, suspension or revocation), you'll be terminated and notified by certified mail of the termination. The notice will inform you to contact the Chief Medical Officer or designee noted in the letter within five calendar days if the information is erroneous.

Call your Provider Relations Representative with questions about our provider credentialing application or participation process at **1-866-638-1232** .

NPI / PROMISe ID enroll and revalidate

The Affordable Care Act (ACA) requires states to revalidate the enrollment of Medicaid providers every five years. Aetna Better Health follows DHS requirements that participating providers revalidate your NPI and PROMISe IDs, along with your service locations, every five years. Failure to complete the revalidation process may result in nonpayment of claims.

Chapter 5

Eligibility and enrollment overview

We provide quality medical, dental and vision services to enrolled Medical Assistance (MA) and Children's Health Insurance Program (CHIP) members. The County Assistance Office determines whether or not an applicant is eligible for MA services. If an individual is does not qualify for Medicaid, they may be eligible for CHIP coverage. Aetna Better Health determines whether or not an applicant is eligible for CHIP services. We make payments to providers and vendors for covered services, medications and medical supplies for enrolled MA and CHIP members.

ACCESS card

The Department of Human Services issues an ACCESS card to each MA member. MA-enrolled health care providers must use this card to access the Department's Eligibility Verification System (EVS) and verify the member's MA eligibility and specific covered benefits.

There are two types of Pennsylvania ACCESS cards providers may encounter . Recipients who are eligible for medical benefits only will receive the yellow ACCESS card. Recipient information is listed on the front of the card and includes the full name of the recipient, a 10-digit recipient number and a 2-digit card issue number.

The Electronic Benefits Transfer (EBT) ACCESS card is blue and green in color with the word "ACCESS" printed in yellow letters. This card is issued to MA recipients who receive cash assistance and/or food stamps as well as medical services, if eligible. Recipient information is listed on the front of the card and includes the full name of the recipient, a six-digit bank code number followed by a 10-digit recipient number, then a two-digit card issue number, and a bank verification number.

Below is an image of a sample medical-benefits only ACCESS card.

Members who are within 30 days of MA enrollment will present with an ACCESS ID card and are covered by MA fee-for-service until they select an MCO. If you participate with Aetna Better Health, you participate with MA fee-for-service and you can provide services to actively enrolled MA members.

Aetna Better Health ID Card

HealthChoices members will also receive an Aetna Better Health Identification Card. Members should present both their Aetna Better Health ID and their ACCESS ID at the time of service. This card includes information on where to submit claims. A sample Aetna Better Health ID card is shown.

Role of EAP and enrollment specialists

The Enrollment Assistance Program (EAP) is responsible for enrollment activities. They employ trained, professional staff called enrollment specialists. The specialists assist eligible Medical Assistance (MA) members in selecting a physical health managed care organization (PH-MCO) and primary care practitioner (PCP) to manage their care. They also provide information regarding HealthChoices Behavioral Health Services.

Verifying eligibility

You can use the ACCESS card to obtain online eligibility information from the Eligibility Verification System (EVS). The EVS is an automated system available to MA providers and other specified organizations for automated verification of MA members' current and past (up to 365 days):

- MA eligibility
- PH-MCO enrollment
- PCP assignment
- Third-party resources
- Scope of benefits

For more information regarding the EVS and ways to access eligibility data, visit **www.dhs.pa.gov/providers/Providers/Pages/EVI.aspx**.

Enrollment procedures

We will enroll any eligible MA member who selects or is assigned to Aetna Better Health, in accordance with rules, regulations and guidelines provided by the Department of Human Services. All members who are determined eligible and select us as their managed care health plan will be enrolled on the date determined by the Department of Human Services. Newborns are considered enrolled as of their birth date, with services being covered immediately by their mother's current Medicaid health plan.

Changing PCPs

If a member is dissatisfied with the auto-selection assignment or wishes to change their PCP for any other reason, the member can choose an alternative PCP at any time by calling Member Services at **1-866-638-1232**. We'll grant the request and process the PCP change in a timely manner. Members will receive a new ID card indicating the new PCP's name.

We maintain policies and procedures allowing members to select or be assigned to a new PCP when:

- The member requests a change
- A PCP is terminated from the network
- A PCP change is required as part of the resolution to a grievance or complaint proceeding
- A provider requests the change of a PCP for reasonable cause

In cases where a PCP has been terminated for reasons other than cause, we'll immediately inform members assigned to that PCP so that they can select another PCP before their current PCP's effective termination date. In cases where a member fails to select a new PCP, we'll reassign the member to another compatible PCP before the PCP's termination date and notify the member of the change in writing.

Enrollment of newborns

Aetna Better Health (MA) newborn enrollment

Aetna Better Health is responsible for services provided to newborns of mothers who are active plan members.

However, infants are not automatically enrolled with Aetna Better Health at birth. Hospitals should immediately notify the county assistance office (CAO) contact located in the mother's county of residence by telephone or fax immediately after the birth of a child to a mother who has valid MA coverage.

Hospitals should follow up on the initial contact within three working days of the child's birth by completing an MA-112 form and submitting it to the appropriate CAO/district office. The newborn cannot be enrolled with Aetna Better Health until DHS opens a case and lists the newborn as eligible for Medical Assistance.

You can find the MA-112 form at **www.dhs.pa.gov/docs/Documents/MA%20Response%20 Forms/Newborn%20Eligibility%20Form.pdf**.

Remember, an EPSDT/Bright Futures (Early and Periodic Screening, Diagnosis and Treatment) screen must be completed for every newborn and submitted to Aetna Better Health.

Aetna Better Health Kids (CHIP) Newborn Enrollment

A child enrolled in CHIP who is identified during her 12-month term of eligibility as being pregnant will remain in CHIP for the duration of the 12-month term.

A child who is identified as being pregnant at the time of renewal will be subject to the usual screening and referral processes to determine eligibility for MA.

A child born to a CHIP enrollee is guaranteed one year of coverage through either MA or CHIP.

The newborn will be covered under the mother's CHIP insurance for the first 31 days from birth using the mother's identification number. A separate CHIP application or eligibility determination is not required.

Retroactive enrollment

Aetna Better Health may occasionally be responsible for approving care as a result of retroactive enrollment.

Example: Aetna Better Health is responsible for a newborn from the child's date of birth when the mother is an active Aetna Better Health member as of that date. The child will have the same MCO history as the mother from birth until added to the Medical Assistance (MA) computer database.

Retroactive requests are evaluated by our Member Services Manager and/or designee for referral to DHS.

However, we are not responsible for retroactive coverage for a member who lost MA eligibility but then regained it within six months. We will begin coverage for the former member on the MA re-enrollment date or the date the recipient is updated in the MA computer data base, whichever is later.

Member rights under Rehabilitation Act of 1973 and the ADA 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 humanservice programs.

Section 504 prohibits organizations from excluding or denying individuals with disabilities and 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 oneself, walking, seeing, hearing, speaking, breathing, working, performing manual tasks and learning. Some examples of impairments, which may substantially limit major life activities, even with the help of medication or aids/devices, are: 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.

Americans with Disabilities Act (ADA)

Title III of the ADA mandates that public accommodations, such as a physician's office, be accessible to those with disabilities. The provisions of the ADA protect qualified individuals with a disability from:

- Exclusion from participation in the benefits of services, programs or activities of a public entity
- Denial of the benefits of services, programs or activities of a public entity
- Discrimination by any such entity

Physicians should ensure that their offices are as accessible as possible to persons with disabilities. They should also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. We offer sign language and over-the-phone interpreter services at no cost to the provider or member.

Providers treating members in the HealthChoices program may not, on the basis of 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 barrier

We will work with you to ensure that qualified individuals with disabilities have access to all medically necessary benefits and services.

Chapter 6

Member rights and responsibilities

We treat our members with respect and dignity. We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression or sexual orientation.

We do not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression or sexual orientation.

Members have responsibilities too. Together, we can advise members of their rights and responsibilities. Review the member rights and responsibilities below.

Communication with members and participating providers

Aetna Better Health members' rights and responsibilities are listed in the Member Handbook and in this Provider Manual. You can access the most current Member Handbook and Provider Manual on our website at **AetnaBetterHealth.com/PA**. Members can request the Member Handbook in print or in another language or format. We notify them by mail when we update the handbook.

We also send written notification if we reduce, suspend, deny or terminate a covered service. Included with this notification is a description of the member's right to appeal such actions, the timeframe for filing such an appeal and the process for submitting the appeal.

Member rights

Aetna Better Health members have the right to information related to their treatment or treatment options in a language they can understand. This includes, but is not limited to:

- Receiving fair treatment and respect
- To be treated with dignity
- Be free from discrimination against race, ethnic group, original country, language, religion, gender identification and age
- The member's mental or physical problems, sexual preference and family medical history are not relevant
- The member's ability to pay is not relevant
- Receiving good quality medical services that support the member's personal beliefs, medical condition and background
- Receiving information from their provider about appropriate or medically necessary treatment options and alternatives for their condition(s) regardless of cost or benefit coverage in a manner appropriate to their ability to understand

- Receiving information about the organization, its services, its practitioners and providers and member rights and responsibilities
- Receiving information regarding the cost of their care
- Receiving language services if they don't speak English, if you're deaf or if you have hearing problems. You can get written information in a different format
- Participating with the providers that make decisions about their health care. The member can have a friend or family member help them with health care decisions when needed. The member's rights include many things:
  - Choosing their own participating PCP
  - Knowing about all of their treatment choices and risks
  - Knowing if care or treatment is part of a research experiment before they have it
  - Saying no to experimental (unproven) treatments
  - Receiving health information from their PCP
  - Receiving information about medical procedures and who will do them
  - Choosing who can be with the member for treatments and examinations
  - Asking to have a female in the room for breast and pelvic exams
  - Refusing a treatment, including leaving the hospital
  - Asking what happens if they refuse treatment
  - Refusing to follow the treatment plan; this does not make a member ineligible for care
  - Stopping medications
  - Receiving necessary and covered services from an out-of-network provider for as long as Aetna Better Health is unable to provide the service in circumstances where the plan cannot offer a choice of two qualified specialists
  - Receiving a second opinion at no cost to the member
  - Receiving medical services when admitted to an emergency department . A member's treatment can't be delayed because of the insurance they have or their ability to pay
- Being free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation
- Privacy: A member's personal and medical information will only be given out as allowed by law. A member has a right to:
  - Receive a copy of their medical records as specified in 45CFR part 164.524 and 164.526
  - Ask for additions or corrections to the records as specified in 45CFR part 164.524 and 164.526

  - Ask how health care information is used
  - Talk to health care professionals and case managers in private
  - Have an Advance Directive (Living Will and Durable Power of Attorney) and receive notification of any change to an applicable state law as soon as possible, but no later than 90 days after the date it goes into effect
  - Voice complaints and grievances about Aetna Better Health and its services
  - Report concerns to Aetna Better Health about the organization
  - Make recommendations regarding the organization's Member Rights and Responsibilities Policy
  - Use all of their member rights without being treated differently or losing any health care services by Aetna Better Health, its providers or the Department of Human Services

Member responsibilities

Aetna Better Health members are responsible for:

- Knowing the name of their PCP and their case manager if they have one
- Knowing about their health care and the rules for receiving care
- Respecting the health care professionals who give them care
- Telling us about their concerns, questions or problems
- Giving their health care providers all the information they need
- Asking for more information if they don't understand their treatment or health condition
- Contributing to their own health by telling their provider about their health care concerns, needs and goals
- Following plans and instructions for care that they agreed to with their providers
- Protecting their member ID card and showing it when they receive services
- Telling us about any other insurance they have
- Telling us if they apply for other health care benefits
- Making appointments during office hours
- Being on time for appointments
- Calling the provider's office 24 hours ahead if they need to cancel an appointment
- Bringing shots record to all appointments for children under 18 years old
- Report fraud, waste and abuse activities

Chapter 7

Medicaid (MA) benefits and cost sharing

Covered benefits and shared costs for HealthChoices members
HealthChoices is the name of Pennsylvania's 1915(b) waiver program to provide mandatory managed health care to members within identified multi-county areas (zones). Medical Assistance (MA) covers eligible MA members for the following medically necessary services as outlined below.

Copayments
The most up-to-date list of copayments is available in the Member Handbook. Copayments do not apply to the following members:

- Pregnant (including postpartum care)
- Under 18 years old
- 18–20 years old and qualify for Medical Assistance under Title IV-B Foster Care or Title IV-E Foster Care and Adoption Assistance
- In a long-term care facility or other medical institution

Copayments do not apply to services provided in an emergency situation or items costing less than $2.

For the most recent listing of covered benefits and copayments, refer to the Member Handbooks for MA and CHIP within the "For Members" section of our website.

To access the MA handbook, go to **AetnaBetterHealth.com/PA/members/Medicaid/handbook**. To access the CHIP member handbook **AetnaBetterHealth.com/PA/members/chip/handbook**.

Maximums

Benefit limit exception process
A member or member's provider can request a benefit exception asking us to approve services above our benefit limits. This is called a benefit limit exception. Benefit limit exceptions are granted when one of the BLE criteria is met:

- The patient has a serious chronic illness or other serious health condition and denial of the exception will jeopardize the life of the patient or result in the rapid, serious deterioration of the health of the patient
- Granting the specific exception is a cost-effective alternative

We'll let you know whether or not the exception is granted within the timeframe given below:

- If the member or member's provider requests an exception before the member receives the service, you'll get a response within 21 days of the date we get the request

- If the member or member's provider requests an exception before the member receives the service and the member's provider tells us the member has an urgent need for a quick response, you'll get a response within 48 hours of the date and time we get the request
- If the member or member's provider requests an exception after the member received the service, you'll get a response within 30 days of the date that we get the request

If the member isn't happy with our decision, he or she can file a complaint and/or a grievance or request a DHS fair hearing about our decision.

The member's doctor or dentist must submit the benefit limit exception request with the following information:

- Member's name, address and member ID number
- The service requested
- The exception rationale
- The provider's or dentist's name, phone number and email

The request must include documentation from the patient's primary care or specialty care physician supporting the need for the exception, e.g., medical/dental history, chart documentation, diagnostic study results, radiographs (if applicable), etc.

Program Exception process

Aetna Better Health has a Program Exception process. The provider or member may request a Program Exception for medically necessary items or services that:

- Are not currently on the Medical Assistance fee schedule
- Are included in the benefit package
- Exceed limits for items or services that are on the Medical Assistance fee schedule (as long as the limits are not based in federal or state rules)

For more information about the Program Exception process, call Member Services at **1-866-638-1232** (PA Relay **711**).

For a dental benefit limit exception mail to: SKYGEN USA, P.O. Box 628, Milwaukee, WI 53201.

For all other benefit limit exceptions mail to: Aetna Better Health of Pennsylvania, Attn: Complaints, Grievances and Appeals, PO Box 81040, 5801 Postal Rd, Cleveland, OH 44181.

Behavioral health services

For Medical Assistance members, the Department of Human Services covers Behavioral Health Services under a separate contract. Physical health services are covered under the Aetna Better Health contract for MA members. For a list of Pennsylvania's BH-MCOs, please refer to DHS's website at **HealthChoices.pa.gov/providers/about/behavioral**.

Aetna Better Health and our providers are required to coordinate and refer identified members to behavioral health services for assessment. Through our Care Management Programs, we can assist in coordination activities and referrals to community resources. Contact Aetna Better Health Care Management at **1-866-638-1232** for help. For more information about our Care Management program, refer to Chapter 9: Medical Management.

For Aetna Better Health Kids members, behavioral health services are provided by CHIP participating providers and facilities in the Aetna Better Health Kids network.

To request an exception to CHIP behavioral health benefits, a benefit limit exception may be submitted. The request must include documentation from the patient's primary care or specialty care physician supporting the need for the exception, e .g ., medical/dental history, chart documentation, diagnostic study results, radiographs (if applicable), etc.

Dental

Dental radiographs, exams (including emergency exams), prophies, FMDs before or after an exam and restorations are a few of the covered services. For members 20 years of age and younger SRPs, prosthodontics, orthodontics and oral surgery are also covered services; however, prior authorization is required. Members 20 years of age and younger are eligible for all medically necessary dental services.

Our subcontractor, SKYGEN USA, will provide details on all of the covered dental services.

Members 21 years of age and older, will be eligible for the above services, with the same prior authorization requirements, with the following exceptions:

- One partial upper or one full upper denture and one partial lower or one full lower denture per lifetime. Additional dentures will require a benefit limit exception (BLE).
- Root canals, crowns and adjunctive services are covered if the member is granted a BLE and does not reside in a nursing facility or in an intermediate care facility (ICF/MR) (ICF/ORC).

Note: SRPs only require a prior authorization and no longer require a BLE.

BLEs are reviewed by a dentist and granted when one of the BLE criteria is met. Please refer to the BLE process section on page 52 for details of the criteria, the process and the address for submission.

Members can find a dentist in their area by accessing **AetnaBetterHealth.com/PA** or by calling Member Services at **1-866-638-1232**. Members do not need a referral to see the dentist.

Durable medical equipment (DME)

DME is covered for most members, but prior authorization may be required. Refer to the prior authorization grid by accessing our secure provider portal at **AetnaBetterHealth.com/PA**.

Covered DME items include, but are not limited to, the following:

- Bathroom and safety equipment
- Beds and accessories

- Electric nerve stimulators
- Lymphedema pump and supplies
- Medically necessary DME and supplies
- Monitoring equipment
- Respiratory equipment and supplies
- Seating equipment (lift chair, wheelchair, commode)
- Wheelchairs

Emergency services

Covered emergency services include:

- Emergency ambulance transportation
- Emergency department (ED)
- ED physician consultation (non-ED specialty)
- ED physician services (radiology, anesthesiology, ED and pathology)

Effective November 1, 2016, we began applying our emergency department claims review policy to Medical Assistance and CHIP claims.

Under this policy, we will review ED claims for appropriate level severity for the diagnosis on the claim. We have posted a list of auto-pay emergency department diagnoses that will automatically allow the claim to process without severity medical record review has been posted on our website.

The full notice is available at **AetnaBetterHealth.com/PA/assets/pdf/provider/notices/ED-policy-provider-notice-eff-11.01.16.pdf**.

Family planning

Members can choose any provider for family planning services. Covered family planning services include, but are not limited to:

- Medically necessary abortions only as allowed by MA Bulletin 99-06-15
- Contraceptive implants/injections
- Education/counseling
- In-office visit with primary care practitioner or primary care obstetrician
- Tubal ligation/hysterectomies/other sterilizations for both male and female are covered for all members over the age of 20. The appropriate consent form must be received at least 30 days prior to, but not more than 180 days before the procedure.
- Long-acting reversible contraception (LARC)
  - Physicians are reimbursed according to MA reimbursement guidelines for the professional component fee for insertion of a LARC or contraceptive implant at the time of an obstetrical delivery.

Hospitals are reimbursed separately for the cost of the device when inserting a LARC intrauterine device (IUD) or contraceptive implant at the time of an obstetrical delivery in addition to the all patient refined-diagnosis related group (APR-DRG) payment that hospitals receive for the delivery.

Health education

Some health educational services may require prior authorization to ensure appropriate utilization. Refer to the prior authorization grid by accessing our secure provider portal at **AetnaBetterHealth.com/PA**.

Hearing

EPSDT/Bright Futures well-child hearing screening is covered for members under age 21. Hearing aids are covered, but require prior authorization for members under age 21.

Home health care

Home health care is a covered benefit, but requires prior authorization. General assistance MA members are limited to 30 days per fiscal year.

Hospice care

We contract with providers certified according to 42 CFR 418.1 to offer hospice care to our members.

Inpatient and outpatient hospice care are covered for those under age 21 and adults who are not on general assistance, but care does require prior authorization. Respite care may not exceed a total of five days in a 60-day-certification period.

Hospital care

The following are covered benefits for hospital care:

- Inpatient hospital stays (acute/rehabilitation).
- Outpatient maternity services and medical observation.
  - Outpatient surgery and maternity surgery.
  - Outpatient diagnostic/therapeutic services are covered for all members.
- Inpatient maternity stays are covered, but require notification to us by the next business day. All rooms are semi-private unless deemed medically necessary.

Laboratory services

Laboratory services are covered if administered by a participating provider. Our preferred laboratory vendors are LabCorp and Quest Diagnostics.

Laboratory services may also be administered within the office with CLIA certification.

Maternity services

Maternity care and obstetrics (OB) services are covered.

Newborn care

Included in EPSDT /Bright Futures services. Refer to Chapter 8: Early Periodic Screening, Diagnosis and Treatment for more information.

Obstetrical/gynecological (OB/GYN) care

Obstetrical and gynecological services do not require a referral, but they must be performed by a participating provider. In situations where a new and pregnant member is already receiving care from a non-participating OB/GYN specialist at the time of enrollment, she may continue to receive services under the continuity of care provision from that specialist throughout the pregnancy as well as postpartum care related to the delivery.

Orthotics/prosthetics

Purchase and fitting of prosthetic devices and supplies, including customized devices, are covered as medically necessary and require prior authorization.

Diabetic and non-diabetic orthopedic shoes are a covered benefit for those under age 21 with prior authorization. Orthopedic shoes are not a covered benefit for those over age 21.

PCP office visits

Regular and routine office visits and procedures are covered.

Prenatal/postpartum care

Maternity Care/Obstetrics is covered. We reimburse Maternity Care/Obstetrics on a fee-for service basis. Nurse midwife (OB) care is covered, including prenatal and postpartum visits. There's a 10-visit limit for postpartum care services. Refer to Chapter 9: Medical Management of this manual for additional Care Management information.

Preventive services

Cervical screening, immunizations, mammograms and prostate/colorectal screenings are covered. Health and wellness services including smoking cessation classes and nutritional counseling are covered, but require prior authorization.

Procedures

In-office procedures (treatment and diagnostics) for PCP and specialists are covered. Refer to the prior authorization grid by accessing our secure provider portal at **AetnaBetterHealth.com/PA**.

The following procedures are also covered:

- Allergy testing
- Angioplasty
- Cardiac catheterization
- Chemo/radiation therapy
- Circumcision
- EMG/NCVs
- Nerve blocks/epidurals
- Sleep studies
- Stents

Radiology (x-ray) services

Angiograms, angioplasty, embolization, bone densitometry, MRI/MRA, PET scans, CT scans, discogram, myelogram, electromyography, other diagnostic radiology procedures and routine x-rays, including portable, are covered. Refer to the prior authorization grid by accessing our secure provider portal at **AetnaBetterHealth.com/PA**.

To request an authorization, submit your request online, by phone or fax:

- Log onto **evicore.com/pages/providerlogin.aspx**
- Call us at **1-888-693-3211**
- Fax an eviCore health care request form (available online) to **1-844-82AETNA**

Skilled nursing facility

Covered for members for 30 consecutive days with prior authorization based on medical necessity.

Skilled home nursing services

Covered for all members with prior authorization based on medical necessity.

Specialist office visits

In-office visits to a specialist are covered. Please refer to page 13 of this manual for information about how to arrange a specialist.

Supplies

Diabetic testing supplies, asthma medical supplies, urinary catheter supplies and other medical supplies are covered for members as medically necessary.

Please refer to our Member Handbook for the most up-to-date list of benefits.

Therapy (occupational, physical and speech)

These services are covered, but they do require prior authorization. For specific prior authorization information, log in to our secure provider portal and refer to the prior authorization grid at **AetnaBetterHealth.com/PA**.

Transplant (organ)

Organ donor costs, organ evaluation, trans plant and transplant facility are covered, but require prior authorization. For specific prior authorization information, log in to our secure provider portal and refer to the prior authorization grid at **AetnaBetterHealth.com/PA**.

Transportation

We cover all medically necessary ambulance transportation and all medically necessary non-emergency ambulance transportation. For specific prior authorization information refer to the prior authorization grid at **AetnaBetterHealth.com/PA**.

Non-emergency transportation is covered by the Medical Assistance Transportation Program (MATP).

MATP is responsible for:

- Non-emergency transportation to a medical service that is covered by the MA program. This includes transportation for urgent care appointments.
- Transportation to another county to receive medical care as well as advice on locating a train, the bus and route information.
- Reimbursement for mileage, parking and tolls with valid receipts if the consumer used their own car or someone else's to get to the medical care provider.

For additional information visit **matp.pa.gov**.

Vision care

Our subcontractor, Superior Vision, will provide covered vision benefit services to members. Members can contact Superior Vision Member Services at **1-800-428-8789**.

Mental health, drug and alcohol services – Medicaid

Through behavioral health managed care organizations (BH-MCOs), MA members receive quality medical care and timely access to appropriate mental health and/or drug and alcohol services. This component is overseen by the DHS's Office of Mental Health and Substance Abuse Services . Refer to Chapter 2: Contact information for these organizations.

Aetna Better Health and our providers are required to coordinate and refer identified members to behavioral health services and for assessment. Through our Care Management Programs, we can assist in coordination activities and referrals to community resources.

For more information about our Care Management program, refer to Chapter 9: Medical Management for more information.

Contact Aetna Better Health Care Management at **1-866-638-1232** for assistance.

CHIP

CHIP covers inpatient detoxification, non-hospital residential treatment and outpatient treatment relating to drug and alcohol abuse for children.

Substance abuse services must be provided by participating providers and facilities unless the use of a non-participating provider or facility is preauthorized.

Some members diagnosed with severe mental health disorders or conditions that significantly impact a child's behavioral health (e.g. schizophrenia, autism, etc.) may be eligible for a broader range of services or different benefit limitations.

For more information about our Care Management program, refer to Chapter 9: Medical Management for more information.

Contact Aetna Better Health Kids Member Services at **1-800-822-2447** if you have questions about your patient's eligibility for certain mental health or substance abuse services or benefit limits. If you have a patient with a drug or alcohol problem, don't delay getting them the help they need. The sooner a child begins treatment with a professional provider, the more likely he or she is to have a successful recovery.

Pharmacy

Prescription drugs must be ordered by a licensed prescriber within the scope of the prescriber's practice. You should write prescriptions for drugs that are preferred on the statewide PDL or Aetna Supplemental formulary whenever possible. Also, your signature should be legible in order for the pharmacy to dispense the prescription. For the most current and up-to-date version of the statewide PDL, visit the Department's website at **https://papdl.com/preferred-drug-list**. For the most current and up-to-date version of the Aetna supplemental formulary, please visit our website at **AetnaBetterHealth.com/PA**.

Statewide preferred drug list (PDL)

Visit **https://papdl.com/preferred-drug-list** for the most updated statewide PDL. Effective January 1, 2020, the PDL is utilized by the Fee-for-Service (FFS) program and all MA managed care organizations (MCOs) that provide outpatient drug services to MA beneficiaries in Pennsylvania. The Department of Human Services' (Department) Pharmacy & Therapeutics (P&T) Committee ("the committee") developed and maintains the PDL. The committee evaluates all drugs on the PDL based on clinical effectiveness, safety, outcomes, and, if drugs are clinically equivalent, cost.

The committee designates the drugs that are determined to be best in a therapeutic class as preferred on the PDL. All MA covered drugs designated as non-preferred are covered and available to MA beneficiaries when found to be medically necessary through the prior authorization process. The FFS program and the MA MCOs use the same prior authorization guidelines to determine medical necessity.

Aetna Supplemental Formulary

This is a drug list created by Aetna Better Health in Pennsylvania ("plan"). The plan will cover drugs on this list in addition to the drugs covered on the statewide preferred drug list (PDL). This list is for drugs and products outside the scope of the statewide PDL. Some drugs may have coverage rules. If the rules for that drug are met, the plan will cover the drug. Non-formulary drugs are also covered when determined medically necessary through the prior authorization process. For the most current and up-to-date version of our supplemental formulary, please visit our website at **AetnaBetterHealth.com/PA**.

Send your request to:

Aetna Better Health of Pennsylvania
Attn: Pharmacy Department
1425 Union Meeting Road
Blue Bell, PA 19422

Quantity limits

Some medications have limits. This means that the member may only get a specific number of pills or dosage within a certain number of days. These limitations are noted on our website at **AetnaBetterHealth.com/PA/providers/pharmacy**.

If you wish to increase the limit for a certain medication for a member, you will need to submit a request showing it is medically necessary to have an exception to the limit(s).

Therapeutic substitution

You must receive permission for a therapeutic substitution. In order for a pharmacist to substitute a prescribed drug for the preferred formulary agent, in the same drug class, the pharmacist must contact the ordering prescriber to receive permission and the necessary new prescription.

Pharmacy prior authorization

We require pharmacy prior authorization if:

- The charge for any single prescription exceeds $9,999
- The prescription requires compounding
- Medications are designated as a specialty medication
- Prescriptions exceed recommended doses or established quantity limits
- Drugs which require certain established clinical guidelines be met before consideration for prior approval
- The prescription is a non-formulary or non-preferred drug
- Established step-therapy protocols have been met

A complete list of all prior authorization guidelines is available at **AetnaBetterHealth.com/PA**.

Procedure for obtaining pharmacy prior authorization

Fax your pharmacy prior authorization requests to **1-877-309-8077**. Use the authorization form designed specifically for pharmacy requests available, which you can find on our website at **AetnaBetterHealth.com/PA**.

Incomplete forms will delay processing of your request. Also, remember to include any supporting medical records that will assist with the review of the prior authorization request. Please allow 24 hours to complete a request.

We'll make available those drugs not on the statewide PDL or Aetna Supplemental formulary when prior authorization and/or step therapy requirements are met.

For medications that require prior authorization, we'll allow a 72-hour supply for new medications or a 15-day supply if the prescription qualifies as an ongoing medication at the time the member presents the prescription at the pharmacy.

Medicaid home-and community-based waiver programs

Outlined below is a list of the current wavier programs available within the Pennsylvania Medicaid Program. Our providers are responsible for providing members with medical services that are not covered under the waiver program covered benefits. To ensure that you have the most up-to-date forms and definitions, you can refer to **www.dhs.pa.gov/Services/Assistance/Pages/Home-and-Community-Based%20Services.aspx**.

- **Aging waiver:** Provides services, supplies and support to persons over age 60 that meet the nursing facility level of care criteria and wish to be treated in their own home or community setting. Services provided include adult day care, transportation, home delivered meals, extended physician services and more.

- **Attendant care waiver:** Helps individuals with physical disabilities perform activities of daily living.
- **Independence waiver:** Provides support and services to persons with physical disabilities that require nursing facility level of care to help them to live in the community and remain as independent as possible.
- **Adult Community Autism Program (ACAP):** Provides services to individuals 21 years or older with a diagnosis of autism spectrum disorder that require intermediate care facility level of care and are able to live in a home or community setting without 16 hours or more per day of staffing and supervision. These services include specific provider services, targeted Case Management, supported employment, assistive technology, family counseling and more.
- **Adult autism waiver (AAW):** Designed for adults 21 years and older who have been diagnosed with autism spectrum disorder that meet intermediate care facility level of care. This waiver applies to all eligible members living in Pennsylvania. Services provided include behavioral health services, speech therapy.
- **Infant, toddlers and family's waiver:** Provides services to children from birth to age three who are in need of early intervention services and would otherwise require the level of care provided in an intermediate care facility for persons with mental retardation or other related conditions (ICF/MR-ORC).
- **Person/family directed support (P/FDS) waiver:** Individuals aged 3 or older who require an ICF/MR level of care with sub-average intellectual functioning and impairments in adaptive behavior. These individuals do not reside in a mental retardation licensed community residential home or a mental retardation licensed family living home.
- **Consolidated waiver:** Provides service to eligible persons over age 3 with sub-average intellectual functioning and impairments in adaptive behavior. These services include community rehabilitation, respite services, transportation, therapy and more.
- **OBRA waiver:** Provides services to persons with severe developmental physical disabilities that manifested prior to age 22 and are over 18. These services include daily living services, community integration services, transportation, supported employment services and more.
- **LIFE (Living Independence for the Elderly Program):** Individuals must be 55 or older, meet eligibility requirements for nursing facility level of care, be able to live safely in the community with services available through the provider and reside in locations where services are available.

Other covered services

We work with the Department of Human Services (DHS) and their vendors to coordinate services that are covered by entities other than us, such as behavioral health and drug and alcohol services, as well as transportation services.

Services requiring referral and prior authorization

The following list represents the majority of services requiring authorization. However, please refer to the code specific and current listing using our secure provider portal at **AetnaBetterHealth.com/PA**. Please note that this listing is subject to change.

All inpatient services

- Surgical and non-surgical
- Skilled nursing
- Rehabilitation
- Hospice

Outpatient services

Outpatient services vary based upon the code and are not location specific. Please check the code specific listings for details. Listed below are selected services requiring prior authorization:

- Surgical services – Refer to code specific listing as requirements may vary
- Home-based services including hospice and skilled nursing

- Therapy – All therapy services require authorization with the exception of therapy diagnostic analysis and therapy evaluations
- Imaging
- MRI
- MRA
- Angiography
- PET scans
- DME – Refer to code specific listing as requirements may vary. In general, the following require authorization:
  - Hospital beds
  - Wheelchairs
  - Oxygen
  - CPAP
- Injectables
- Therapy management services provided by a pharmacist – refer to code specific listing as requirements may vary
- Orthotics / prosthetics
- Implantable devices
- Electronic devices
- Implantable breast prosthetics
- Injectable bulking agents
- Other
  - Sleep studies
  - Osteopathic manipulation and chiropractic services
  - Specialized multidisciplinary services
  - Enteral feeding supply, formulas, additives and all pumps
  - Some supply-based services
  - Some hearing and vision services
  - All unlisted codes require authorization

Emergency services

No authorization is required for emergency services. Non-emergent ambulance transportation does require authorization.

Consultations performed using telemedicine

Aetna Better Health of Pennsylvania offers telemedicine services to support our members with receiving health care services remotely.

Telemedicine is the use of real-time interactive telecommunications technology that includes, at a minimum, audio and video equipment as a mode of delivering consultation services.

While face-to-face consultations with the patient are preferred whenever possible, we recognize that there are instances where face-to-face consultations are not feasible.

In these instances, telemedicine is considered an effective alternative in increasing patient access to specialist care, improving quality of care, and promoting better communication and coordination among providers.

Aetna Better Health will allow two-way, real-time interactive communication while the patient is at an enrolled originating site and the licensed physician at a distant site.

A referring providers presence is not required at the originating site at the time the visit, however in situations where the referring provider or other physician, CRNP or CNM is not physically present, a nurse or other clinical professional may assist the patient.

Providers are reminded to render services face-to face wherever practical and appropriate. Providers should fully document the following information in the MA recipient's medical record, in accordance with MA regulations at 55 Pa. Code § 1101.51 relating to ongoing responsibilities of providers:

- The specific interactive telecommunication technology used to render the consultation
- The reason the consultation was conducted using telecommunication technology, and not face-to-face

For more on the telemedicine program or determining feasibility for the use of telecommunication technology, providers may reference information in the MA Bulletin: **dhs.pa.gov/docs/Publications/Documents/FORMS-AND-PUBS-OMAP/d_005993.pdf**

Our Provider Relations team is also available to assist. Please call **1-866-638-1232** for further details.

CHIP benefits and cost sharing

Covered benefits for CHIP members

This section lists the medical services covered by CHIP. All services must be medically necessary. The services in this section are in alphabetical order.

Under each covered service listing you will find a brief description of the benefit provided and any limits or restrictions that may apply. We reserve the right to restrict benefit coverage of medical equipment purchases to certain manufacturers and specific product types.

Except under very specific circumstances, such as in the case of an emergency, all services described in this section are covered only if provided by a participating provider. Except in the case of an emergency, preauthorization by Aetna Better Health Kids or other specialized documentation or certifications required for a particular benefit, must be obtained before a child receives the service in order for the claim to be covered.

We only cover services up to the specified benefit limits.

Autism spectrum disorder and related services

In accordance with the Pennsylvania Autism Insurance Act (Act 62), the following services, when medically necessary for the assessment, diagnosis and treatment of autism spectrum disorders are covered:

- Prescription drug coverage including over-the-counter (OTC) medications, vitamins and aspirin
- Services of a psychiatrist and/or psychologist
- Rehabilitative and therapeutic care

There are no benefit limits. Coverage does not include case management services. Coverage under this section is subject to copayments as identified in the CHIP handbook.

Treatment of autism spectrum disorders must be:

- Medically necessary and prescribed by a physician or other independently licensed health care professional with prescribing authority
- Identified in a treatment plan
- Provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clincial social worker, licensed behavior specialist (a person licensed in Pennsylvania to provide applied behavioral analysis) or certified registered nurse practitioner
- Provided by an autism service provider or a person, entity or group that works under the direction of an autism service provider

Diabetic services

Medically necessary diabetic treatment, equipment, medications and supplies as follows:

- Diabetic medical equipment, monitoring supplies and prescription medications
- Outpatient diabetic training and education
- Diabetic eye examinations
- Laboratory screening tests
- Routine diabetic foot care and orthotics
- Aetna Better Health Kids Diabetic Disease Management Program
- Aetna Better Health Kids Special Needs Unit care coordination and Case Management

Benefit is limited to one routine diabetic eye exam per benefit year. Batteries for diabetic medical equipment are not covered. Services identified above are subject to the same benefit limits noted in the CHIP member handbook.

Diagnostic, laboratory and radiology services

Medically necessary diagnostic tests, services and materials related to the diagnosis and treatment of sickness and injury in both inpatient and outpatient settings are covered. Certain services may require prior authorization in order to be covered.

Durable medical equipment

Medically necessary durable medical equipment (DME) coverage applies to equipment designed to serve a medical purpose such as:

- A CHIP member has an illness or an injury.
- It is able to stand repeated use.
- It's not disposable or for a single patient use.
- It's required for use in the home or school environment. This benefit covers the cost of DME rental (or purchase, if purchase is cheaper than renting the DME over an extended period of time), delivery and installation.

We only cover the repair or replacement of DME as required with normal wear and tear when medically necessary.

DME may require prior authorization. Any DME request over $500 may require review by our medical director.

Emergency care services

CHIP members do not need pre-authorization for emergency ambulance transportation or emergency care in the hospital. Hospitals must treat CHIP members if they have a medical emergency. CHIP members should not use the emergency department for follow-up care. We may not cover follow-up care in the emergency department.

Just like MA members, you should educate CHIP members and their parents on when it is appropriate to visit the emergency department.

Emergency transportation services

Transportation services by land, air or water ambulance are covered only when medically necessary. Services must be rendered in the following situations:

- In response to an emergency
- For the purpose of transporting an inpatient member between facilities
- When a homebound member is discharged from the hospital and for medical reasons cannot be transported by other means

We'll only cover transportation outside of the service area if the services required by the member cannot be provided within the service area.

Family planning services

Family planning services cover the professional services provided by a CHIP member's PCP or OB GYN provider related to the prescribing, fitting and/or insertion of a contraceptive. This includes Food and Drug Administration approved contraceptive methods, including contraceptive devices, injectable contraceptives, IUDs and implants, voluntary sterilization procedures and patient education and counseling, not including abortifacient drugs, at no cost share to the member. Contraception drugs and devices are covered under the Prescription Drug benefit issued with the plan.

Gender transition services

The CHIP Program and Aetna Better Health Kids cover gender transition services such as physician's services, inpatient and outpatient hospital services, surgical services, prescribed drugs, therapies, etc. when deemed medically necessary and appropriate.

Medical necessity will be determined based upon the World Professional Association for Transgender Health (WPATH) Standard of Care.

Habilitative services

Habilitative services are health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech language pathology and other services for people with disabilities in a variety of outpatient settings.

Covered services are limited to 30 visits per benefit year for physical therapy; 30 visits per benefit year for occupational therapy; and 30 visits per benefit year for speech therapy, for a combined visit limit of 90 days per benefit year. Visit limits under this benefit are combined with visit limits described under outpatient rehabilitation therapy.

Covered services also include inpatient therapy up to 45 visits per calendar year for treatment of CVA (Cerebral Vascular Accidents), head injury, spinal cord injury or as required as a result of a post-operative brain surgery.

Hearing care services

If medically necessary, hearing aids and devices and the fitting and adjustment of such devices, are covered.

This benefit is limited to one routine hearing exam and an audiometric exam per 12 months, one hearing aid or device per year every 12 months. Batteries are not covered. No dollar limits apply.

Home health care services

Home health care is only covered if a CHIP member is homebound. Home health care services include medically necessary:

- Physician services
- Physical, speech and occupational therapy services
- Medical and surgical supplies and equipment, including oxygen
- Home infusion therapy (not including blood or blood products)

Home health services may require prior authorization by Aetna Better Health Kids. There are no copayments and no limitations.

Hospice services

Hospice is a special kind of care that is available to CHIP members who suffer from a terminal illness. This care will be concurrent with care related to the treatment of the condition for which the diagnosis of terminal illness was made. Members getting hospice and palliative care services may still receive Aetna Better Health Kids covered services for other illnesses or conditions as well.

Hospice services must be prior authorized by Aetna Better Health Kids and require a certification by a physician stating that the member has a terminal illness. Aetna Better Health Kids must be provided with a written request for hospice services by either the member, if they're of legal age, or by the member child's legal guardian.

Hospital services

Inpatient, outpatient and ambulatory surgical center service

Hospital services must be provided by a participating facility on either an inpatient or outpatient basis and must be medically necessary. These services may be provided at participating facilities, such as an acute care hospital, skilled nursing facility or an ambulatory surgical center.

Inpatient benefits for medical and behavioral health hospitalizations, medically related inpatient rehabilitation and skilled nursing services are not limited. Inpatient medically related rehabilitation therapy is not limited.

Outpatient physical health services relating to ambulatory surgery, outpatient hospitalization, specialist office visits and follow-up appointments or sick visits with a CHIP member's PCP are not limited. Hospitalization related services may require prior authorization except in the case of an emergency.

Mastectomy and breast cancer reconstructive surgery services

Mastectomy and breast cancer reconstructive surgery services are performed on an inpatient or outpatient basis and for the following:

- Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy, surgery and reconstruction of the other breast to produce a symmetrical appearance

- Coverage for initial and subsequent prosthetic devices to replace the removed breast or portions thereof due to a mastectomy
- Physical complications of all stages of mastectomy, including lymphedemas
- Coverage is also provided for one home health care visit, as determined by the CHIP member's physician, received within 48 hours after discharge

Mastectomy services may require prior authorization.

Maternity services

A female CHIP member may select a participating provider for maternity and gynecological services without a referral or prior authorization. Except in the case of an emergency or in accordance with the continuity of care policy, participating providers must provide maternity services at participating facilities.

Providers of maternity care services may include:

- Physicians
- Nurse practitioners
- Certified nurse midwives
- Facilities may include both acute care hospitals and free-standing birthing centers

Hospital and physician care services relating to antepartum, intrapartum and postpartum care, including complications resulting from the member's pregnancy or delivery are covered. If the member's eligibility changes when they are in the second or third trimester of the pregnancy, they may remain through the postpartum stage with the same physician or practitioner.

Under federal law, health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a delivery by cesarean section.

However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

CHIP members can also receive one home health care visit following an inpatient release for maternity care if the member is released prior to 48 hours for a normal delivery or prior to 96 for a caesarean delivery in consultation with the mother and provider or in the case of a newborn, in consultation with the mother or the newborn's authorized representative.

Home health visits include, but are not limited to: parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. A licensed health care provider whose scope of practice includes postpartum care must make such home health care visits. At the mother's sole discretion, the home health care visit may occur at the facility of the

provider. Home health care visits following an Inpatient stay for maternity services are not subject to copayments, deductibles or coinsurance, if otherwise applicable to this coverage.

If a pregnant member joins Aetna Better Health in her second or third trimester and her provider is out of network, she may continue to see that provider through the pregnancy and postpartum period.

In the same way, if we end our contract with a pregnant member's doctor and the member is in her second or third trimester, she may continue to see that provider through the pregnancy and postpartum period.

Delivery at a facility outside the service area will only be covered in the case of an emergency.

Medical foods

Medical foods such as specially formulated enteral feedings and supplements are covered only for the medically necessary therapeutic treatment of certain genetic disorders. This benefit isn't intended to be normal food products used in the dietary management of rare genetic metabolic disorders.

Medical foods require prior authorization and must be prescribed by a physician or nurse practitioner. Special kinds of infant formulas are not medical foods and are not covered.

Newborn coverage of infants born to CHIP members

This benefit pertains to newborn children of CHIP members who are covered from the time of birth for the first 31 days of life. CHIP members can access these services using the member's CHIP identification card. To assure no lapse in access to health care for the newborn after the first 31 days, the member must contact Member Services at **1-800-822-2447** immediately after child is born to begin the process of getting the newborn his or her own health care coverage.

This service ends after the CHIP member's baby turns 31 days of age. Members with newborns should follow the guidelines set forth in the CHIP member handbook to access their benefits.

Oral surgery services

Oral surgery services may be performed in either an inpatient or outpatient setting depending on the nature of the procedure and require prior authorization. Examples of covered services include:

- Extraction of partially or totally bony impacted third molars (wisdom teeth)
- Baby bottle syndrome (early childhood dental caries)
- Surgery to correct dislocation or complete degeneration of the temporomandibular joint

- Non-dental treatments of the mouth relating to medically conditions such as:
  - Congenital defects
  - Birth abnormalities
  - Surgical removal of tumors

We reserve the right to determine, based on medical necessity, what facility setting is most appropriate for the oral surgery services being provided. Anesthesia coverage varies based on the procedure and the type of facility where the service is provided. All services related to oral surgery require prior authorization.

Orthotic devices

Orthotic devices are rigid appliances or apparatuses used to support, align or correct bone and muscle injuries or deformities. This benefit covers the purchase, fitting and necessary adjustments of covered orthotic devices. It also covers the required repair because of normal wear and tear on the device.

Replacement of an orthotic device is only covered when it is deemed medically necessary. There is no limit to this benefit.

Ostomy supplies

Ostomy supplies are medical supplies necessary for the care and drainage of a stoma. There is no limit to this benefit.

Outpatient medical therapy services

This benefit provides CHIP members with an unlimited number of medically necessary outpatient visits for the following services:

- Dialysis treatments
- Cancer chemotherapy and hormone treatments
- Respiratory therapy
- Radiation therapy

This benefit may require prior authorization. The CHIP member must have a documented diagnosis that indicates that the prescribed therapy is a medical necessity.

Outpatient rehabilitative therapy services

This benefit provides CHIP members with the following medically necessary rehabilitative services:

- Physical therapy
- Occupational therapy
- Speech therapy

Coverage is limited to 30 days each of physical, occupational and speech therapy, for a combined total limit of 90 days outpatient therapy.

Primary care practitioner office services

Preventive and well child visits and services include the following, with no cost sharing or copays:

- Coverage will be provided for pediatric Immunizations (except those required for employment or travel), including the immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control, U.S. Department of Health and Human Services. Pediatric Immunization ACIP schedules may be found by at **cdc.gov/vaccines/schedules/index.html**.
- Influenza vaccines can be administered by a participating pharmacy for members starting at 9 years old, with parental consent, according to PA Act 8 of 2015.
- Sick and urgent care office visits including those that occur after normal office hours when medically necessary. These visits include well baby care, which generally includes a medical history, height and weight measurement, physical examination, routine diagnostic tests and counseling.
- Blood lead screening and lead testing. This blood test detects elevated lead levels in the blood.
- Oral health risk assessment, fluoride varnish for children ages 5 months to 5 years old (US Preventive Task Force Recommendation).
- Follow-up care after emergency services.
- Women's health services and family planning services (see benefit description for details).
- Genetic counseling and testing – there are no limits for this benefit.

Other preventive services

Benefits are covered for:

- All items and services recommended by the United States Preventive Services Task Force with a rating of A or B in the current recommendations, including:
  - Dental cavities prevention for preschool children
  - Healthy diet counseling
  - Oral fluoride supplementation
- BRCA risk assessment and genetic counseling and testing
- Prescribed Vitamin D
- Prescribed iron supplementation
- Chlamydial infection screening of pregnant women
- Chlamydial infection screening for non-pregnant women
- Sexually transmitted infections counseling
- Folic acid supplementation
- Tobacco use counseling and interventions
- Benefits as recommended by the Advisory Committee Immunization Practices (ACIP) of the Center for Disease Control and Prevention
- Benefits as recommended by the Health Resources and Services Administration (HRSA), including:
  - All Food and Drug Administration-approved contraceptive methods
  - Sterilization procedures
  - Breast feeding equipment
  - Patient education and counseling for all women with reproductive capacity

Prosthetic devices

Prosthetic devices replace all or part of a missing body part and are medically necessary. They're also used to help a non-functioning organ to work again. This benefit covers the purchase, fitting and necessary adjustments of covered prosthetic devices. It also covers required repair that resulted from normal wear and tear on the device.

Replacement of a prosthetic device is only covered when deemed medically necessary and appropriate due to the normal growth of the child.

There is no limit to this benefit.

Restorative or reconstructive surgery services (other than mastectomy-related services)
Covered services for medically necessary restorative and reconstructive surgery include services relating to:

- Surgery to correct a deformity resulting from:
- Disease
- Trauma
- Congenital or developmental anomalies (birth defects) through the age of 18
- Infection
- Surgery to correct a bodily functional defect resulting from:
  - Accidental injury
  - Incidental to surgery
  - Surgery in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment, in order to achieve reasonable physical or bodily function

There is no limit to this benefit.

Skilled nursing inpatient facility services
Skilled nursing services are available if deemed medically necessary to children requiring around the clock skilled nursing services but not needing to be in a hospital.

There is no limit to this benefit.

Inpatient private duty nursing is covered in full.

Specialist physician services
Office visits, diagnostic testing and treatment by specialists are covered when provided by a CHIP network provider. There is no limit to this benefit.

Transplant services
Transplant services that are medically necessary and not considered experimental or investigative by Aetna Better Health Kids are covered. Prior authorization is required.

Covered services for patient selection criteria (testing required by the transplant facility to make sure a child is eligible for a transplant) are covered at only one designated transplant facility except when the services are rendered as part of a second opinion that has been prior authorized by Aetna Better Health Kids. This benefit does not provide coverage for services related to the donation of organs to non-members.

Urgent care services
As described in the urgent care section of the CHIP member handbook. There is no benefit limit.

Urological supplies

Urological supplies required for medically necessary urinary catheterization are covered only for a CHIP member that has permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected for a child within three months.

There is no benefit limit. Any DME request over $500 may require review by our medical director.

Women's health services

There is no cost sharing for preventive services under the services of Family Planning, Women's health and contraceptives. Well-woman preventive care includes services and supplies as described under the women's preventive services provision of the Patient Protection and Affordable Care Act. Covered services and supplies include, but are not limited to, the following:

- Pelvic exam, clinical breast exam and routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists
- Family planning services (refer to benefit described previously for further details and limitations)
- Maternity services (refer to benefit described previously for further details and limitations)
- Treatment of gynecological illness, including injury or complications that result from an elective abortion

The annual gynecological examination and associated services are limited to one per benefit year. Except in cases of an emergency, abortion services may require prior authorization.

Abortions will only be covered if a physician has certified the abortion is medically necessary to save the life of the mother or if the abortion is performed to terminate a pregnancy resulting from an act of rape or incest. The incident of rape or incest must have been reported to law enforcement authorities or child protective services, unless the treating physician certifies that in his or her professional judgment, the member is physically or psychologically unable to comply with the reporting requirement.

Contraception

Food and Drug Administration approved contraceptive methods, including contraceptive devices, injectable contraceptives, IUDs and implants; voluntary sterilization procedures and patient education and counseling, not including abortifacient drugs, at no cost share to the CHIP member.

Contraception drugs and devices are covered under the prescription drug benefit issued with the plan.

Mammograms

Coverage will be provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992. Copayments do not apply to this benefit.

Breastfeeding

This benefit includes comprehensive support and counseling from trained providers; access to breastfeeding supplies, coverage for an electric breast pump; and coverage for lactation support and counseling provided during postpartum hospitalization, mother's option visits and obstetrician or pediatrician visits for pregnant and nursing women at no cost to the member. Coverage for rental of a hospital-grade breast pump requires prior authorization.

Osteoporosis Screening (Bone Mineral Density Testing or BMDT)

Coverage is provided for bone mineral density testing using a U.S. Food and Drug Administration-approved method. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a professional provider legally authorized to prescribe such items under law.

Pharmacy

We provide coverage for a broad range of prescription drugs. Our CHIP formulary explains which medications are covered. Typically, we won't pay for drugs not included in the CHIP formulary.

- Some medications in the formulary may require prior authorization
- Some medications may only be covered if a member has met certain criteria. Examples include having the health care provider submit documentation that the member has:
  - Certain medical conditions or diagnoses that indicate the medication is medically necessary
  - Drug allergies that limit the use of other medications a member might be treated with
  - Unsuccessful treatment of a condition or illness with a different medication without success

CHIP mental health benefits

Inpatient benefits for medical and behavioral health hospitalizations, medically related inpatient rehabilitation and skilled nursing services are not limited.

There are no limits for mental health outpatient visits per benefit year. Covered services include:

- Psychological testing
- Visits with mental health providers
- Partial hospitalization
- Intensive outpatient therapy
- Medication management

CHIP substance use disorder benefits
CHIP covers inpatient detoxification, non-hospital residential treatment and outpatient treatment relating to drug and alcohol abuse.

Covered services include:

- Psychological and laboratory testing
- Visits with substance use disorder rehabilitation providers
- Partial hospitalization
- Intensive outpatient therapy
- Medication management

CHIP dental benefits
CHIP covers dental services necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions. There are no copayments for dental services.

CHIP doesn't cover dental services performed for cosmetic purposes rather than medical necessity. CHIP also doesn't cover more treatment due to noncompliance with prescribed dental .

CHIP vision / eye care benefits
Aetna Better Health Kids covers emergency, preventive and routine vision care:

- Lenses
- Contact lenses are covered if medically necessary in lieu of a set of glasses
- Frames

Chapter 8

Early Periodic Screening, Diagnosis and Treatment/Bright Futures Overview

Early Periodic Screening, Diagnosis and Treatment (EPSDT)/Bright Futures 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. These intervals are based on the recommendations of the American Academy of Pediatrics (AAP), American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD). All PCPs who provide services to members under age 21 are required to provide comprehensive health care, screening and preventive services. We require our network PCPs to provide all EPSDT/ Bright Futures services in compliance with federal and state regulations and periodicity schedules. You can find the most recent periodicity guidelines on the Pennsylvania DHS website for the HealthChoices program at **www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_291410.pdf**.

Current recommended childhood and adolescent immunization schedules can be viewed at **www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html** as well as in Chapter 16: Helpful links to forms and schedules.

Identifying barriers to care

Understanding barriers to access is essential to ensuring that members receive appropriate care including regular preventive services. We find that although most parents 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/Bright Futures services. To address this, we train our Member Services and Care Management staff to identify potential obstacles to care during member communications opportunities. We also train our staff to work with family members/caregivers, PCPs and other relevant entities to ensure access to services.

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

- Cultural or linguistic issues
- Lack of perceived need if children are not sick
- Lack of understanding of the benefits of preventive services
- Competing health-related issues or other family/work priorities
- Lack of transportation
- Difficulties with scheduling 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

Call your Provider Services Representative at **1-866-638-1232** for help arranging any of these services.

Screening, diagnosis and treatment

You're required to make the following recommended and covered services available to EPSDT/ Bright Futures-eligible members at the ages recommended on the periodicity schedule. Providers are required to complete EPSDT/Bright Futures screening services within 45 days of the member joining your practice.

Screening services, provided at recommended ages in the child's development, include all of the following:

- Comprehensive health and developmental history, including nutritional and developmental assessments (WIC evaluations and child abuse assessments are also included when necessary)
- Inpatient physician visits and routine inpatient and outpatient screenings provided for newborns.
- Comprehensive physical exam including unclothed
- Appropriate immunizations (in accordance with the Advisory Committee on Immunization Practices (ACIP) schedule)
- Laboratory tests, including urinalysis, hemoglobin/hematocrit count, Tuberculosis testing and lead toxicity screening
- Health education including anticipatory guidance, child development, healthy lifestyles, 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, relief of pain and infections, restoration of teeth and maintenance of dental health (oral exam by PCP should begin at age one with a referral to a dentist beginning at age three)
- Hearing services, including, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids
- Diagnostic services, including referrals for further evaluation whenever such a need is discovered during a screening examination
- Treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services
- Developmental delay and autism spectrum screening
- Lead poisoning prevention

Practitioners are expected to do the following in providing EPSDT/Bright Futures services:

- Avoid delays in pediatric screenings and services by taking advantage of opportunities (for instance, provide an immunization or screening during a sibling's visit)
- Give immunizations to members in accordance with federal and commonwealth standards
- Comply with our Minimum Medical Record Standards (contained in the Provider Agreement) for Quality Management, EPSDT/Bright Futures Guidelines and other requirements under the law
- Cooperate with our periodic reviews of EPSDT/Bright Futures services, which may include chart reviews to assess compliance with standards
- Report members' EPSDT/Bright Futures visits by recording the applicable Current Procedural Terminology (CPT) preventive codes on the required claim submission form

If you detect a suspected problem during a screening examination, you must evaluate the child as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

If you suspect developmental delay following an EPSDT/Bright Futures screening and the child is not receiving services at the time of the screening, you must refer the child (not over 5 years of age) to CONNECT at **1-800-692-7288** for the appropriate referral to local Early Intervention Program services.

We track treatment needs as we identify them. We also assure that appropriate follow-up is pursued and reflected in the medical record.

Omnibus Budget Reconciliation Act (OBRA) of 1989 entitles individuals under the age of 21 to receive all medically necessary health care services contained in Section 1905(a) of the Social Security Act and required providers to treat a condition diagnosed during an encounter. Any medically necessary health care procedure or service that is eligible under the federal Medicaid program is covered except for Behavioral Health Services, which will be covered through the Behavioral Health Program. Providers are responsible for identifying members in need of behavioral health treatment services, notifying us and assisting members by referring them to appropriate behavioral health providers under the state's Behavioral Health Program.

We work collaboratively with PCPs to provide SSI and SSI-related members under age 21 a comprehensive assessment of their anticipated primary and specialty health needs over a 12-month period. This assessment determines if the member would benefit from Care Management intervention. If the PCP recommends Care Management and the member's family/caregiver consents, we'll enroll the member in our Care Management program. Our Care Managers discuss the results of the child/adolescent's assessment with the family/caregiver (or custodial agency) and develop an appropriate plan of care.

We'll inform the family/caregiver in writing about the plan and explain the process for submitting a complaint if they disagree with the member's proposed care plan.

Tracking

We track compliance with EPSDT/Bright Futures guidelines in the following areas:

- Initial visit for newborns. The initial EPSDT/Bright Futures screen is the newborn physical exam in the hospital.
- EPSDT/Bright Futures screen and reporting of all screening results.
- Diagnosis and/or treatment or other referrals for children.

We also track and report to DHS on a variety of EPSDT/Bright Futures screenings and treatments including:

- Number of comprehensive screens (reported by age)
- Hearing and vision examinations
- Dental screens
- Age-appropriate screens
- Complete age-appropriate immunizations
- Blood lead screens
- Prenatal care for teen mothers
- Provision of eyeglasses to those in need of them
- Dental sealants
- Newborn home visits
- Referral of very low birth weight babies to early intervention
- Referral of members under the age of 21 with elevated blood lead levels to early intervention
- Routine evaluation for iron deficiencies
- Timely identification and treatment of asthma

Follow-up and outreach

We'll work with you to assure that members with EPSDT/Bright Futures needs are identified and treated in a timely and appropriate manner. We submit reports to DHS identifying provider performance in the four required services:

- Screening
- Diagnosis and treatment
- Tracking
- Follow-up and outreach

Arranging for medically necessary follow-up care for health care services is also an integral part of each provider's continuing care responsibility after a screen or any other health care contact. In cases involving a member under the age of 21 with complex medical needs or serious or multiple disabilities or illnesses, our Case Management services must be offered. You can reach our Case Management staff at **1-866-638-1232** to arrange these services.

We closely monitor EPSDT/Bright Futures metrics throughout the year to identify trends and potential opportunities for improvement. We also identify any children who have not yet received a Well-Care visit in the last 12 months as a priority for follow-up. We continuously update our interventions database that includes children with missing services and contact information for the member and the provider. Also, each month we calculate provider level HEDIS rates at the group level for the previous 12-month period.

Then, we identify which members have gaps in care.

Our reminders for follow-up and outreach to members include:

- Written notification of upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of members.
- Telephone calls to remind members of upcoming visits and follow-up on missed appointments within a set time period.
- Help with transportation when requested so members can get necessary EPSDT/Bright Futures screening services. Assistance is offered prior to each due date of a child's periodic examination.
- Outreach to non-compliant members, including home visits, as appropriate.
- Outreach and follow-up to members under the age of 21 with special needs.

We mail monthly age-appropriate reminders to all households with children under the age of 21, with frequent reminders for every age group from 2 to 18 years. The mailings remind parents/guardians to make sure their child receives:

- An unclothed physical exam
- A physical, mental and social health history overview
- Hearing, dental and vision screenings
- Nutrition and health education
- Lab screenings and testing as needed
- Required immunizations

In addition, tips are provided for parents on the age-appropriate topics to discuss with their providers.

To assist in provider monitoring for follow-up in the four required services (Screening, Diagnosis, Treatment, Tracking and Follow-up and Outreach) for children in substitute care, we maintain master lists of all enrolled children coded as such on the monthly membership files. Specific staff is assigned to monitor the services provided to these children and to ensure that they receive comprehensive EPSDT/Bright Futures screens and follow-up services. Our staff contacts the relevant agencies with custody of these members or with jurisdiction over them (e.g., County Children and Youth Agency, Juvenile Probation Office) when a particular child has yet to receive an EPSDT screen/Bright Futures or is not current with their EPSDT/Bright Futures screen and/or immunizations. We also ensure that an appointment for such service is scheduled.

We also submit reports to the Department of Human Services providing all data regarding children in substitute care (e .g ., the number of children enrolled in substitute care who have received comprehensive EPSDT/Bright Futures screenings, the number who have received blood level assessments, etc.).

Our Care Managers are responsible for coordinating and tracking EPSDT/Bright Futures services, including services for children and adolescents with developmental disabilities, behavioral health needs and complex health problems who are enrolled in the Care Management program.
All assessments evaluate members under the age of 21 to identify needed EPSDT/Bright Futures visits and incorporate these services into the care plan. Care Managers use a variety of care management tools (e .g ., CORE, our proprietary predictive modeling application) and assessments to identify members in need of coordination of care and schedule targeted outreach calls. They enter information gathered from these activities into Dynamo™, our customized care management tracking application. This enables Care Managers to review a member's encounter history, schedule needed appointments and plan follow-up activities.

In addition to outreach to members participating in our Care Management program, we generate reports to identify members who are due or past due for EPSDT/Bright Futures screenings and services. We perform targeted outreach through reminder mailings, phone calls and mailing a monthly flyer to parents/guardians of children under the age of 20 who are due for an EPSDT/Bright Futures visit. For members under the age of 6, an EPSDT/Bright Futures coordinator will call after these mailings to remind members about the importance of well-child visits.

PCPs are required to contact new members identified in the quarterly encounter lists who haven't:

- Had an encounter during the first six months of enrollment
- Complied with scheduling requirements for screenings, testing and treatment

PCPs must also contact members identified as not complying with the EPSDT/Bright Futures periodicity and immunization schedules for children to set up appointments. If members don't comply within one month of being contacted by the PCP, the PCP must notify us. The PCP must document the reasons for noncompliance, where possible and document efforts to bring the member's care into compliance with EPSDT/Bright Futures standards.

PCPs must also contact all members who have not had an encounter during the previous 12 months or within the appointment standards timeframes established in the Provider Agreement.

On a quarterly basis, an outreach call is made to members who haven't received EPSDT/Bright Futures services within the recommended timeframes. If necessary, Care Managers will make up to three additional efforts to contact parents and guardians by telephone. If those attempts are unsuccessful, we'll send another letter and initiate any extra follow-up needed in order to reach the member, including researching returned mail and contacting the member's PCP's office for assistance (for members who are enrolled in Care Management).

If needed, a Care Manager will contact a member's PCP every six months to inquire whether an EPSDT/Bright Futures visit occurred . If an EPSDT/Bright Futures visit didn't occur, we'll ask the PCP to reach out to the parent/guardian to schedule an appointment.

Educating members and providers about EPSDT/Bright Futures services

We have a comprehensive strategy for educating members and providers about the importance of preventive health screenings and immunizations.

These strategies include, but are not limited to:

- Member educational materials
- Provider educational materials
- Integration of information into Care Management Programs (e.g., care coordination, Care Management and Disease Management)

Members

We inform members about the availability and importance of EPSDT/Bright Futures services through:

- Our new member welcome packet
- Our Member Handbook
- Our member newsletters and bulletins
- Aetna Better Health's website: **AetnaBetterHealth.com/PA**
- Our educational flyers
- Our reminder postcards
- Our reminder calls
- Our text messages
- Our care plan interventions for high-risk members enrolled in Care Management or Disease Management

Providers

We conduct provider educational and outreach activities designed to emphasize the importance of EPSDT/Bright Futures screenings and services and help you more readily identify patients overdue for services. These activities help you document preventive services and identify and resolve other issues that impede provider participation, including reimbursement. We work with you to increase compliance with EPSDT/Bright Futures screening and treatment standards through the following strategies:

- Providing online training modules and access to educational websites
- Increasing reimbursement for preventive care services
- Linking pay for performance criteria to preventive service delivery rates
- Implementing Initiatives to increase well-child and dental visits
- Developing clinical practice guidelines specific for EPSDT/Bright Futures

- Developing member profiling and provider report cards that target EPSDT/Bright Futures services
- Conducting on-site visits with providers to identify barriers to care
- Conducting an annual audit using HEDIS® criteria and American Academy of Pediatrics screening standards to improve compliance with EPSDT/Bright Futures benchmark
- Establishing a Special Needs EPSDT/Bright Futures Workgroup comprised of PCPs whoserve children and youth with developmental disabilities where “best practices” and strategies for improving EPSDT/Bright Futures screening rates can be shared
- Implementing performance improvement plans that include EPSDT/Bright Futures, if needed

We work collaboratively with providers to stress the importance of EPSDT/Bright Futures screenings and services. We also closely monitor compliance with established benchmarks and produce periodic reports for PCPs showing which members need EPSDT/Bright Futures services.

Please note that failure to submit a claim for complete EPSDT/Bright Futures screenings and services may result in denial of payment.

Interagency teams

For the ongoing coordination of EPSDT/Bright Futures services for members under the age of 21 identified with special needs, our staff will ensure coordination with community-based organizations, schools and other appropriate entities. Our staff works collaboratively with these organizations, the member (if appropriate), the member’s family/caregiver and other stakeholders to develop a comprehensive plan of care for the delivery of all medically necessary and appropriate services. This includes pediatric care and other specialized services, whether covered or uncovered and whether in- or out-of-network . As needed, we also initiate Care Management interventions for members under the age of 21 with complex and/or co-morbid conditions.

Substitute care or residential facility placement

We work with you to meet the following requirements for children and adolescent members who have been placed in substitute care or in a residential facility.

Children and adolescent members placed in foster care

- Ensure that the child/adolescent receives a health screening within 60 days of his or her admission to foster family care, unless he or she has had a screening within the previous 90 days and the results of the evaluation are available. The screening must include:
  - Review of the child's health history
  - Physical examination
  - Appropriate laboratory or diagnostic tests, including those required to detect communicable disease
- Ensure the child/adolescent receives immediate attention when a medical problem is recognized at the time of referral
- Ensure that the child/adolescent receives age-appropriate well-child visits and screenings on an ongoing basis according to the following schedule:
  - Birth to 6 months: should be seen monthly
  - 6 months to 24 months: should be seen once every three months
  - 24 months up to 21 years old: should be seen twice a year

Children and adolescent members placed in residential and day treatment facilities

- Ensure that the child/adolescent receives a written health and safety assessment within 24 hours of admission. This assessment includes:
  - A comprehensive medical exam and history, including physical, dental, behavioral and emotional health, as well as the identification of ongoing medical care needs
  - Documentation of known or suspected suicide or self-injury attempts or gestures and emotional history which may indicate a predisposition for self-injury or suicide
  - Documentation of known incidents of aggressive or violent behavior
  - Documentation of substance abuse history
  - Documentation of sexual history or behavior patterns that may place the child/adolescent or other children at a health or safety risk

We keep a copy of the assessment in the member's record in accordance with all federal and commonwealth regulations, including HIPAA. We assign specific staff to monitor services provided to members in substitute care or residential facilities. This helps ensure that the member receives all recommended EPSDT/Bright Futures screenings and follow-up services. We also submit comprehensive performance reports to the Department of Human Services.

Chapter 9

Medical Management Overview

Our Medical Management Program encompasses activities directed toward prospective, retrospective and concurrent utilization review. It also covers Integrated Care Management and Disease Management services.

Prospective Review (Prior Authorization) determines the medical necessity and appropriateness of the service before it's provided. Concurrent review determines the appropriateness of the level of care and length of stay throughout a member's inpatient stay. Retrospective review involves assessment of the appropriateness of medical services after the services have been provided.

Care Management Services assist physicians with members who have special needs, complex health problems and/or high-risk pregnancy. Our Disease Management Programs help members to manage their chronic illnesses.

Our Integrated Care Management (ICM) Program uses a bio-psycho-social model (BPS) 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 high risk of not doing well over the next 12 months. We offer them intensive Care Management Services built upon a collaborative relationship with a single clinical case manager, their caregivers and their primary provider. This relationship continues throughout the Care Management engagement. We also offer supportive Care Management Services to members who are at lower risk. Supportive care includes standard clinical Care Management, service coordination and support.

To support our Care and Disease Management activities, we use our proprietary health risk assessment, questionnaires and predictive modeling software. A customized Care Management application enables our Care Management team to work closely with members, their families and providers to help improve clinical outcomes and enhance the quality of life for members. Our predictive modeling and self-report tools fully integrate physical and behavioral health conditions along with psychosocial risks and protective factors to identify members who would benefit from Care Management and then stratify them into intensive and supportive levels of service.

We use three tools to identify complex, high-risk members. We then assign them to one of these levels of Care Management Services. The tools we use to identify the right members for ICM include:

- Predictive modeling using our CORE analysis
- Self-report – Health Risk Questionnaire (HRQs) and/or their state-mandated alternatives
- Surveillance – Daily census, readmissions and other "traditional" case finding methods

The functionality of the Care Management software includes:

- Case finding tools
- Outreach questionnaire
- Integrated clinical assessments
- Integrated care plan
- Correspondence
- Condition-specific assessments
- Member satisfaction survey
- Audit tools
- Reporting (e.g., tracking of member outcomes)

Our Utilization Management and Quality Management staff works with providers, monitoring the care provided to members and performing the following functions:

- Coordinating member services, including:
  - Detecting inappropriate patterns of care (e.g. over-or under-utilization of services, including pharmacy)
  - Identifying diagnoses or multiple co-morbidities that place members at risk for serious consequences
- Monitoring compliance with treatment protocols, including:
  - Untreated co-morbid conditions
  - Gaps in care, such as a failure to fill prescribed medications or get a flu shot based on evidence-based guidelines
  - Use of medications that are less than optimal for chronic conditions (e.g., rescue medication for asthma when controller medications would be more optimal)

- Assessing provider performance, including:
  - Adherence to evidence-based clinical guidelines, including prescribing patterns
  - The delivery of care or services which, if improved, could enhance member safety and health outcomes
  - The provision of providing preventive screenings and treatments
- Tracking and trending quality measures, including:
  - Verification that emergency and inpatient hospital services are appropriately used
  - Post hospital discharge services are adequate, including medication regiment
  - Inpatient readmissions are reduced
  - Inappropriate use of the emergency department

Medically necessary

All services provided to members must be "medically necessary" and delivered at the appropriate level of care.

A service or benefit is "medically necessary" if it's compensable under the Medical Assistance Program and if it meets any one of the following standards:

- The service or benefit will or is reasonably expected to, prevent the onset of an illness, condition or disability
- The service or benefit will or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability
- The service or benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age

Determination of "medically necessary" for covered care and services, whether made on a prior authorization, concurrent review, retrospective review or exception basis, must be documented in writing.

The determination is based on medical information provided by the member, the member's family/caretaker and the PCP, as well as any other providers, programs, and/or agencies that have evaluated the member.

All such determinations must be made by qualified and trained health care providers. A health care provider who makes such determinations of medical necessity is not considered to be providing a health care service under this Agreement.

Please note: Services previously determined to be medically necessary, authorized and scheduled shall not be denied or cancelled based upon eligibility and benefits.

Prior authorization, concurrent review and retrospective review criteria

We use the MCG® criteria to ensure consistency in hospital–based utilization practices. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The MCG are updated regularly as each new version is published. Copies of individual guidelines are available for review upon request.

To support prior authorization, concurrent review and retrospective review decisions, we use nationally recognized evidence-based criteria with input from health care providers in active clinical practice. We apply these criteria on the basis of medical necessity and appropriateness of the requested service, the individual member's circumstances and applicable contract language concerning the benefits and exclusions. The criteria will not be the sole basis for the decision.

For inpatient medical care reviews and for elective inpatient and outpatient medical services, we use the following medical review criteria.These are to be consulted in the order listed if the specific request is not addressed by that set of criteria:

- Criteria required by the DHS and the Pennsylvania HealthChoices contract
- Applicable MCG
- Aetna Better Health Clinical Policy Bulletins (CPBs)
- Aetna Clinical Policy Council Review

For prior authorization of elective inpatient and outpatient behavioral health services, Aetna Better Health Kids (CHIP) uses the following clinical review criteria. These are to be consulted in the order listed:

- Criteria required by applicable state regulatory agency or client contract
- Applicable MCG
- Aetna Clinical Policy Bulletins (CPBs)
- Aetna Clinical Policy Council Review

We annually review criteria sets for appropriateness to our needs and change as applicable in order to reflect current medical standards. The annual review process involves appropriate practitioners in developing, adopting or reviewing criteria. You can get a copy of the utilization criteria upon request.

Prior authorization, concurrent review and retrospective review requests are presented to the designated medical director for review when the request does not clearly meet criteria applied as defined above. Before making a determination of medically necessary, the reviewing medical director may contact the requester to discuss the case or may consult with a board-certified physician from an appropriate specialty area.

The prescribing or treating practitioner may request a peer review to discuss a medical necessity denial with a medical director reviewer.

You can request a copy of the Medical Necessity Criteria by sending a written request via fax to **877-363-8120** or by mail to:

Aetna Better Health of Pennsylvania
Attn: Medical Management Department
1425 Union Meeting Road
Blue Bell, PA 19422

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 securing an authorization number to ensure reimbursement of claims. Information in the prior authorization request for concurrent review must validate the medically necessary 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
  - Current Procedural Terminology (CPT)
  - International Classification of Diseases, 10th Edition (ICD-10)
  - Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure CodingSystem (HCPCS) codes
  - National Drug Code (NDC)
- Name, date of birth, gender and identification number of the member
- Primary care or treating provider
- Name, address, phone and fax number and signature, if applicable of the ordering provider
- Name, address, phone and fax number of the rendering 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

Inpatient admission notifications received from the facility's administrative offices, including admissions, business or finance, satisfies the requirement to notify us of an admission. These notifications will be processed as an authorization once the required information to validate medically necessary outlined in this section is provided.

Decision and notification standards

We adhere to the following timeframes when notifying PCPs, prescribing clinicians and members of prior authorization, concurrent review and retrospective review decisions:

Type of Decisions	Decision	Initial Notification	Written Confirmation
Emergency/urgen tadmissions	Immediate, no prior authorization required	N/A	N/A
Drugs	24 hours from receipt of request	24 hours from receipt of request	24 hours from initial notification
Home Health	48 hours from receipt of request	48 hours from receipt of request	2 business days from initial notification
Request for additional information	14 days from the receipt of the request	Within 48 hours of receiving the request	2 business days after the decision is made
All other services	21 days from the receipt of the request	2 business days from the receipt of the request	mailed by the 18th day from the receipt of the request
Urgent precertification	24 hours from receipt of request*	24 hours from receipt of request	24 hours from initial notification
Non-urgent precertification	2 business days from receipt of the request**	2 business days from receipt of the request	2 business days from initial notification
Urgent concurrent review	24 hours (1 calendar day) from receipt of the request*	24 hours (1 calendar day) from receipt of the request	24 hours (1 calendar day) of the initial notification*
Retrospective review	30 calendar days from receipt of the request	30 calendar days from receipt of the request	30 calendar days from receipt of the request

*The timeframes for decisions and notification may be extended if additional information is needed to process the request.

**During non-urgent preservice request, in circumstances where there is insufficient information to make a determination the provider will be given 14 calendar days to provide additional information.

If we need more facts, documents or information to make a decision, we will request it from the appropriate practitioner within 48 hours of receiving the request. The practitioner has 14 days to submit the additional information. We also notify members of requests for more information on the date we request it from the practitioner.

If the practitioner provides the additional information within 14 days, we make a decision toapprove or deny the service and notify the member, member's PCP and prescribing practitioneraccording to the timeframes in the table above.

If we don't receive the requested information within 14 days, we make a decision to approve or deny the service based upon the available information and notify the member, member's PCP and prescribing practitioner according to the timeframes above.

You can request a copy of the Medical Necessity Criteria by sending a written request via fax to **877-363-8120** or by mail to: Aetna Better Health, Attn: Medical Management Department, 1425 Union Meeting Road, Blue Bell, PA 19422.

Denial, reduction, suspension or termination of services

We notify the prescribing practitioner, member's PCP and member in writing of any decision to deny, reduce, suspend or terminate a service authorization request or to authorize a service in an amount, duration or scope that is less than requested.

Our medical directors conduct medical review for each case identified as a potential denial of authorization. The requesting physician may be asked to submit more information. Based on the discussion with the physician or additional documentation submitted, the medical director will decide to approve, deny, modify, reduce, suspend or terminate an existing or pending service.

Clinical medical necessity determinations are based only on the appropriateness of care and service and the existence of coverage. Aetna Better Health 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 inpatient denials, the attending physician and hospital staff are verbally notified when we stop payment. The hospital will receive written notification with the effective date of termination of payment or reduction in level of care. The attending or referring physician may dispute the finding of the medical director informally by phone (peer to peer) or formally in writing. If the finding of the medical director is disputed, a grievance or a request for a DHS Fair Hearing may be filed according to the established grievance and fair hearing process.

Peer-to-peer consultation

Our medical directors participate in the utilization review process and conduct clinical review. They're available to discuss review determinations with attending physicians or other ordering providers. We'll notify practitioners/providers verbally, at the time of notification of the denial, that they may request a peer-to-peer consultation to discuss denied authorizations with the medical director reviewer. We provide, within one business day of a request by the attending physician or ordering practitioner, the opportunity to discuss the denial decision:

- With the medical director making the initial determination
- With a different medical director if the original medical director cannot be available within one business day
- If a peer-to-peer conversation or review of additional information does not result in a certification, the denial letter informs the practitioner/provider and member of the right to initiate an appeal and the procedure to do so

Discharge planning coordination

Our Concurrent Review Nurses assist hospital staff in coordinating appropriate individualized discharge plans for members' post-hospital care. The concurrent review nurses assist with, but don't duplicate discharge services that Medicare, Medicaid and the Joint Commission on Accreditation of Healthcare Organization (JCAHO) require hospitals to provide.

Our post-hospital planning function is carried out under the direction of the Chief Medical Officer (CMO) by Concurrent Review Nurses who are responsible for:

- Coordinating the member's post-hospital discharge planning with facility personnel
- Documenting the member's hospital discharge plans upon the initial review and ongoing as needs are identified
- Documenting the member's discharge date and status within 24 hours of knowledge of the discharge

Designated Case Management staff members are responsible for:

- Calling the member within 3 business days of the member's discharge date if required*
- Determining whether the member obtained appropriate supplies and scheduled appointments*
- Determining whether a case and/or Disease Management case needs to be opened to further assist the member with their health care needs

*If we cannot reach the member after at least three calls, we send the member a letter on day five as an additional outreach attempt.

Medical claims review

We identify certain claims to determine whether services were delivered as prescribed and consistent with our payment policies and procedures. In these instances, our Medical Claims Reviewers:

- Determine whether the documentation provided supports the billing.
- Review whether billed charges are necessary and reasonable.
- Identify non-covered supplies and services along with inappropriate and undocumented charges. The Medical Claims Reviewers report any cases of potential fraud or abuse to our Compliance Department for review.

Case Management

Our Chief Medical Officer is responsible for directing our Care Management program with the assistance of the Director of Medical Management and the Manager of Care Management. This includes ensuring the incorporation of clinical practice guidelines into our Care Management practice and program. Our Case Managers are RNs and other independently licensed physical and behavioral health professionals. Case Managers along with other Care Management staff perform the day-to-day Care Management functions. These employees are trained on the special health care needs of the member population, Care Management approaches and motivational interviewing to improve member engagement.

Our Integrated Care Management (ICM) Program uses a bio-psycho-social model (BPS) 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 high risk of not doing well over the next 12 months. We then offer them intensive Care Management Services built upon a collaborative relationship with a single Clinical Case Manager, their caregivers and their primary care practitioner. This relationship continues throughout the Care Management engagement. We also offer supportive Care Management Services to members who are at lower risk. These include standard clinical Care Management along with service coordination and support.

ICM considers all the member's needs as they relate to their current and future health. We achieve this by evidence-based member identification and stratification. Our predictive modeling and self-report tools fully integrate physical and behavioral health conditions along with psychosocial risks and protective factors to identify members who would benefit from Care Management. The members are then stratified into intensive and supportive levels of service.

These steps are followed by assessment, case formulation and case planning. Highly skilled Case Managers interview members entering intensive Care Management to identify the root causes driving poor health and the critical barriers to improvement.

These might be related to their physical health or behavioral health conditions directly, to psychosocial issues that impact the member's ability to participate effectively in their own care or to barriers created by the health care system itself. The member and Case Manager then collaborate to identify the highest priority issues, goals important to the member and activities to reach those goals. Engaging and motivating members to make critical changes in persistent patterns of behavior and to assume greater responsibility for their health as Care Management progresses are essential skills for the Case Managers.

Members entering supportive Care Management have fewer complex-presenting issues that typically respond well to straightforward problem solving.

These are more likely to be condition-specific or are related to the need for coordination of different elements of the member's treatment and support services. Supportive Case Managers and Care Management Associates help members resolve these issues effectively, safely and quickly.

The final element of ICM is accountability for outcomes. We strive to measure the member's ability to achieve and sustain better health by becoming a more engaged and activated participant in their own health care and making better use of more appropriate health care resources.

Integrated Care Management (ICM) guiding principles:

- Moving from disease-focus to member-focus philosophy: Evaluating every member for physical, behavioral and social risks to their current and future health.
- Identifying and employing the most effective intensity of evidence-based, plan-covered systems and services: Facilitating access to a continuum of services based on the intensity and complexity of each member's needs.
- Incorporating behavioral engagement for change: Using a single point of contact to engage each member in a plan that addresses his or her critical physical, behavioral and social needs to promote resiliency, recovery and optimal self-management.
- Teaming 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 system's framework to manage psychosocial complexity and challenging relationships with members and their families.
- Collaboration with plan sponsors to influence benefit design: Focus on coordinating and integrating fragmented services into a system of care that addresses each member's individual needs within the context of their family and cultural community.

ICM key components

Focus on:

- Right members
- Right people, right skills
- Individualized, relationship-based care
- Bio-psycho-social care planning
- Electronic tools
- Interdisciplinary case rounds
- Progression of care
- Outcomes accountability

We offer Case Management services to help you serve members who have special needs and/or complex health problems. Case Management services assist members in gaining access to necessary medical, behavioral, social, educational and other services.

Case Management services may be offered to members who are at high risk for:

- Complications during their pregnancy
- Developing a chronic debilitating disease
- Drug dependency
- Noncompliance with medication or treatment plan
- Multiple medical or social needs
- Requiring frequent contact and follow-up
- Long-term home care IV or enteral therapy
- Special needs programs

When a member enrolls in the Aetna Better Health Case Management program, we'll assign the member to a case manager or care coordinator. The case manager or care coordinator will work with the member's primary care practitioner/specialist, community case managers or other program case managers to develop a care plan. The care plan uses a goal-oriented process that moves the member toward optimal health and wellness and encourages the member to take an active role towards self-care. The goals are to improve the member's health outcomes and the member or caregiver's ability to self-manage the condition.

If you have a member that you believe would benefit from our Case Management Program because of a special health care need, serious, chronic, disability or complex medical condition, complete the Case Management Referral form and fax to **1-877-683-7354**. If you have questions concerning the Case Management Program, call **1-866-638-1232**.

Disease Management

Our Disease Management (DM) program provides an integrated treatment approach that includes the collaboration and coordination of patient care delivery systems. It focuses on measurably improving clinical outcomes for a particular medical condition. This is accomplished through the use of appropriate clinical resources such as:

- Preventive care
- Treatment guidelines
- Patient counseling
- Education
- Outpatient care

It includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition.

Our DM program assists you in managing members diagnosed with targeted chronic illnesses. The illnesses targeted are those that have been shown to respond to coordinated management strategies.

They've also shown to frequently result in exacerbations and hospitalizations (high-risk) that require high usage of certain resources and that incur high costs. Our DM program has six components:

- Population identification processes
- Evidence-based practice guidelines
- Collaborative practice models that include physician and support-service providers
- Patient self-management education
- Process and outcomes measurement, evaluation and management
- Routine reporting/feedback loop (including communication with members, physicians, ancillary providers and provider profiling)

We identify members as candidates for the Disease Management Program through a stratification process using claims data and ICD-10 codes through our predictive modeling program. If a member is stratified and placed into the high-risk category, a representative from our program will contact the member and complete an assessment to determine enrollment in the DM program.

Disease Management oversight

Our Chief Medical Officer is responsible for:

- Overseeing the DM programs in collaboration with the Senior Medical Director of Clinical Operations.
- Participating on the Disease Management (DM) Steering Committee, along with the Aetna Better Health disease management manager.
- Reviewing Disease Management reports monthly and making recommendations to our QM/UM committees, the Quality Management Oversight Committee (QMOC) and the DM program as applicable.

Our DM Department is responsible for helping to coordinate members' care within the DM program in the following ways:

- Managing internal functions and processes that are integrated with the DM program to promote the smooth coordination of members' care and services (e .g ., Prior Authorization, Case Management, Member Services)
- Coordinating functions or activities that need to be handled locally (e .g ., prior authorization, referrals to local resources, communications with member's primary care practitioners)
- Receiving referrals for any members identified by their primary care practitioners, family members, themselves, an Aetna Better Health department or through the predictive modeling/stratification database

- Coordinating communications between providers and the DM Department as necessary
- Receiving Case Management referrals and referring members back upon completion of DM goals, if applicable
- Generating weekly or monthly member-specific reports from the DM database for review with the chief medical officer, presentation to our internal medical committees and submission to applicable entities if required by contract

The DM Department also carries out day-to-day Disease Management operations, including:

- Identifying potential DM members using the predictive modeling/stratification database
- Conducting initial questionnaires of potential DM members and enrolling them in the program, if applicable
- Educating members about their disease process and effective self-management strategies
- Developing a goal-oriented plan of care for each member
- Evaluating at least monthly members' progress toward goals and the effectiveness of the program, with more frequent evaluations if the case indicates
- Communicating members' progress updates to their primary care practitioners
- Identifying members who meet criteria for referral to Case Management or Behavioral Health Care Management
- Assessing each case after six months for completion of goals and, if applicable, risk stratification to low risk
- Providing monthly reports of aggregate DM program outcome measures for each plan with an Aetna Medicaid Business Unit DM program
- Annually surveying member and provider satisfaction with the program

Plan-specific DM programs are structured to include nationally recognized, evidence-based guidelines, risk group interventions, risk scores, assessment of outcomes data and report formats.

We also utilize a National Committee for Quality Assurance (NCQA) Certified Disease Management Program to assist members in reducing the frequency and severity of exacerbations of a chronic illness. We do this by improving the member's health status and helping to appropriately self-manage their disease. We developed our programs using nationally recognized evidence-based guidelines. We distribute all DM guidelines to all contracted providers.

DM programs available to members include:

- Asthma (children and adults)
- Diabetes (children and adults)
- Congestive heart failure (CHF)/coronary artery disease (CAD)
- Chronic obstructive pulmonary disease (COPD)

For our pediatric Medicaid and CHIP members, we developed DM programs for children with asthma and diabetes. Also, all of our DM programs address co-occurring physical concerns like obesity, hypertension and behavioral health conditions like depression and anxiety. We collaborate with the BH-MCOs to assure that HealthChoices members with chronic and/or complex physical health conditions also receive needed treatment for behavioral health conditions. This collaboration helps to assure that members with primary behavioral health diagnoses (e.g., serious emotional disturbance) receive needed physical health services.

If you have a member who has one of the above listed chronic conditions, e.g. asthma, diabetes, CHF or COPD, you or your staff can make a referral to our Disease Management program at any time. To make a referral, call **1-866-638-1232** and ask for Disease Management.

We provide Clinical Practice Guidelines for asthma, diabetes, chronic congestive heart failure and chronic obstructive pulmonary disease. You can get a copy of the guidelines through our web portal at **AetnaBetterHealth.com/PA**.

Members identified with special needs

We manage the care of members with special health care needs through our Case Management Department. The Case Management Department operates under the direction of our Chief Medical Officer and Special Needs Director of Medical Management. The department's primary responsibility is to work aggressively to identify and assess special needs members prior to the onset of an adverse event. To this end, the Special Needs Unit:

- Provides care coordination/Case Management
- Works as an advocate for special needs members throughout Aetna Better Health
- Collaborates with others involved in each member's care (e.g., BH-MCOs, OCYF, community agencies, schools, etc.)

Our Special Needs Unit staff has direct access to the plan medical director, a behavioral health coordinator and case managers with specialized expertise in the diverse and complex needs of members with chronic and/or complex health conditions.

To refer a patient to our Special Needs Unit, call **1-855-346-9828** or fax a referral form. The case management special needs referral form is available on our website at **AetnaBetterHealth.com/PA/assets/pdf/provider/provider-forms/Blank-CM-referral-form-2018.pdf**.

Linking special needs members with practitioners

All members require a source of primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective. Typically, a primary care practitioner (PCP) provides this type of care. However, special needs members may need a specialist to act as a PCP if the member has a disease or condition that is life threatening, degenerative or disabling. For example, a pediatric pulmonologist may be the preferred PCP for a child with cystic fibrosis. Physicians in a specialized HIV/AIDS clinic may be the best source of primary care for our members with that diagnosis. Our Special Needs Unit will facilitate these PCP relationships, as appropriate.

Many special needs members may not require a specialist to manage their care, but need PCPs who are knowledgeable about their condition(s). Our members always have the option to select or to change their PCP. Refer to Chapter 3: General information for additional information.

Coordination of Care

We tailor our Case Management Care Coordination Model for special needs members in several ways, including:

- Carefully managing staff caseloads to reflect the complexity of special needs members
- Ensuring that special needs coordinators have the appropriate expertise to manage the care of their assigned members (e .g ., behavioral health, out-of-home placement, home-based services, skilled nursing)
- Providing care coordination planning that is member-centric, holistic, integrated, collaborative and culturally competent

For each of our special needs members, the care planning process integrates the full range of services required by that member, regardless if they're covered under HealthChoices, Medicaid fee-for-service, a Medicaid waiver or not covered under Medicaid at all, including state-funded services and community resources. Whatever the circumstance, our staff will develop care plans in collaboration with the relevant stakeholders in a member's care (e .g ., BH-MCOs, Area Agencies on Aging, Medicare, early intervention programs, home-and community-based waiver case managers, schools, subsidized adoption agencies, juvenile justice, ICF MRs, residential treatment facilities, extended acute psychiatric facilities, adolescent and adult substance abuse treatment programs, family members and other caregivers).

Healthy Beginnings Plus Program and Perinatal Case Management

The DHS Healthy Beginning Plus program (HBP) covers pregnant women and children up to 12 months if the mother is eligible for MA benefits at the time of the child's birth and the child continues to live with the mother. Prenatal care for women and infants must meet or exceed HBP standards outlined in the Department's MA Bulletins. Services include comprehensive prenatal and postpartum care.

Our prenatal, perinatal and postpartum Care Management supports and fulfills the goals of the Healthy Beginnings Plus program. The following services are available to enrolled and eligible pregnant members.

Covered perinatal Care Management range from pre-conception counseling through postpartum care address both clinical and social needs. Care is also provided in a manner that accommodates members' cultural needs (e.g., for language translation). The services may include:

- Pre- and Perinatal Case Management for high-risk members
- Outreach contacts, such as telephone reminders of appointments, referrals and follow-up calls
- Maternity care services from a qualified health care professional or specialist (a participating obstetrician), a primary care practitioner experienced in maternity care, a certified nurse midwife or perinatologist
- Health risk questionnaires to identify high-risk populations and appropriate interventions
- Education, available through mailings or group classes
- Social support services to address individual risks, such as smoking cessation classes, alcohol and/or substance use disorder treatment, services to address spousal or partner abuse and emotional or mental health concerns
- Family planning services whenever appropriate
- Referrals to community resources, such as the Women, Infants and Children (WIC) Program, birthing or nutrition resources, behavioral health or other resources to assist the member with other needs, such as housing and transportation, if applicable
- Coordination with programs in the community that support the member's needs (e.g., high schools for teen mothers, hospital-or church-sponsored programs)

All HBP providers must follow DHS billing guidelines for correct reimbursement

Prenatal and perinatal program components

Identification of pregnant members

The identification of pregnant members can be through:

- An external source
- The results of a health-risk questionnaire from the state regulator
- The member or a provider
- An internal process or referral, such as review of pharmacy reports, laboratory reports, emergency department logs or concurrent review

Any internal department that receives information identifying a pregnant member directs the information to the Case Management Department through the call tracking system or by forwarding the applicable referral or records to the department.

Health-risk questionnaire

A Perinatal Case Manager conducts outreach to each identified pregnant member to administer a health-risk questionnaire, which becomes the foundation of the member's pregnancy record.

The questionnaire includes:

- Demographic information (including the member's educational and family status)
- General history of the member's health
- Nutritional status
- Psychosocial issues (such as domestic or sexual abuse, alcohol and/or substance use)
- History of the member's previous and current pregnancies

The case manager documents the member's responses in the perinatal Case Management database and evaluates indicators of medical or social risk to determine the need for intervention. Medical or social risks could include:

- Late initiation of prenatal care
- Maternity alcohol and/or substance abuse
- Pre-term labor
- History of postpartum depression

Maternity care practitioner

We encourage pregnant members to promptly select a maternity care practitioner. Here is a list of practitioners who may possibly qualify and subject to our policies and procedures:

- A participating obstetrician, a certified nurse midwife or certified nurse practitioner, who handles only the member's maternity care while the member's PCP retains responsibility for the member's general health care.
- The member's PCP, if he or she is experienced in caring for pregnancies.

The member may choose a maternity care practitioner referred by her primary care practitioner or to a network practitioner of her own choosing. In situations where a new (and pregnant) member is already receiving care from an out-of-network OB/GYN specialist at the time of enrollment, the member may continue to receive services from that specialist throughout the pregnancy and postpartum care related to the delivery. If the practitioneris not contracted with us, a Case Manager and/or Member Services Representative will coordinate the authorization necessary for the practitioner to continue the member's care until postpartum care is completed.

Our network includes perinatologists to provide care and monitoring for members with high-risk conditions. A member's Maternity Care Practitioner may refer her to a perinatologist for consultation and evaluation at any point during pregnancy.

Certified nurse midwives

Our members may select a certified nurse midwife working under the direct supervision of a participating obstetrician. Such a coverage arrangement must be approved by our Chief Medical Officer.

Any midwife providing services to Aetna Better Health's members must:

- Provide, by contract, only services within the scope of his/her specialty
- Be credentialed by Aetna Better Health
- Meet state licensing and certification requirements
- Have clinical privileges at a participating licensed clinical facility with established maternity care services (e.g., hospital, freestanding maternity center)

Perinatal Case Management Services

Perinatal Case Management Services educate pregnant members on how to use the maternity care services available. They also assist those with complex clinical or social issues to obtain the support services they need. Case Managers assist members in developing a plan of care to meet their individualized needs. An individual's risk factors determine the interventions we use to overcome barriers to care and promote a healthy pregnancy that will result in healthy outcomes for the newborn and mother. Case Managers provide an important link between members, their providers and community resources or agencies, such as health departments. As an advocate for the member, the Case Manager is able to coordinate care and services to focus on the specific individual member's needs.

Pregnant member education

Education of pregnant members includes the following information, presented by the Case Manager and the member's practitioners, through group classes or in mailed materials:

- Education in healthy practices is integrated into the care of all expectant members, including:
  - Education about and support for breastfeeding
  - Referral to the Women, Infants and Children (WIC) Program for supplemental nutrition
  - Special education for complex cases (e.g., diabetes)
  - Importance of folic acid to a healthy pregnancy
- Pregnancy
  - Prenatal
  - Fetal development
  - Labor and delivery

- Postpartum
  - Postpartum self-care
  - Postpartum depression
  - Family planning
- Infant care
- Availability of enhanced services such as referrals for social service or health education and referrals for:
  - Special supplemental nutrition program (WIC)
  - Dental care
  - Child health services (for other children)
  - Family planning
- Availability of testing for HIV/AIDS and other sexually transmitted diseases
- Availability of counseling if HIV/AIDS test results are positive
- Prenatal/childbirth classes

Oversight of Perinatal Case Management

Perinatal operations are carried out under the direction of our Chief Medical Officer (CMO) and/or designee. The CMO is responsible for overseeing the core operations and activities and monitoring productivity. Case Management Perinatal staff member coordinates the outreach, questionnaire and intervention processes. Staff members include licensed nurses and social workers experienced in maternity care and social issues.

Our Perinatal Case Management responsibilities include:

- Maintaining adequate staff with appropriate experience in perinatal care services:
  - Medical directors specializing in maternity care (either Aetna Better Health staff, corporate medical directors or contracted practitioners)
  - Maternal Health/EPSDT/Bright Futures Coordinator (CMO): a licensed physician, registerednurse or physician's assistant or who has an MA degree in health services, public health or health care administration experienced in obstetrics and managed care
  - Perinatal Case Managers (licensed nurses and social workers experienced in maternity care)
  - Care coordinators
  - Outreach staff
  - Support staff
- Maintaining a network of providers qualified to deliver services during the pregnancy and postpartum, including:
  - Participating obstetricians
  - Primary care practitioners qualified to provide obstetrical care (including physician assistants and nurse practitioners)
  - Perinatologists
  - Neonatologists
  - Certified nurse midwives
- Providing members with educational materials and information to enhance the educational materials provided by the member's maternity care practitioner
- Educating providers about our Case Management program and how to refer members

Perinatal case managers are responsible for the following:

- Conducting risk questionnaires to identify members in the high-risk category
- Assisting members in selecting a provider qualified in maternity care, if necessary
- Encouraging members to keep perinatal appointments
- Assisting members in developing a plan of care to meet their individualized needs and determining and carrying out interventions indicated by the member's risk level
- Making follow-up contacts as applicable to remind and educate members
- Documenting and tracking information about members' pregnancies, interventions, referrals and outcomes

Practitioner's responsibilities

Our website includes information about the Perinatal Case Management program, how providers can refer members to the program and the maternity care standards. Visit **AetnaBetterHealth.com/PA**. The information is found under "Health & Wellness."

Practitioners who provide maternity care are responsible for Completing the Obstetrical Needs Assessment Form (ONAF) and submitting to Aetna Better Health. This form should be completed electronically through our secure portal and submitted to the plan. The ONAF is located at **AetnaBetterHealth.com/PA/assets/pdf/provider/provider-forms/OBNAF-PA.pdf**.

Discuss and share information with the member regarding:

- The physical changes to be expected during pregnancy
- The process of labor and delivery
- Breast feeding and other infant care information
- The importance of complying with the care plan
- Nutritional recommendations and maintaining healthy behaviors
- Complying with the standards of care recommended by the American College of Obstetrics and Gynecology (ACOG), including use of a comprehensive medical risk assessment tool and ongoing monitoring
- Coordinating the member's maternity care needs throughout the pregnancy and providing postpartum care between 21 and 56 days of delivery
- Referring members as necessary for medical specialty services, such as Perinatology or to Aetna Better Health's Case Management Department for coordination of other services
- Complying with our time standards for first-time appointments and ACOG-recommended standards for return appointments (see the tables below)
- Assessing for possible depression and making appropriate referrals

First Prenatal Appointment Time Standards	
Pregnancy Status	**First Appointment Time**
First trimester	Within 10 business days of identification
Second trimester	Within 5 business days of identification
Third trimester	Within 4 business days of identification
High-risk condition	Within 24 hours of identification
Emergency condition	Immediately upon identification

Pregnancy Status	**Return Visit Frequency**
Through 28 weeks	Every 4 weeks
Between 29 and 36 weeks	Every 2 weeks
After week 36	Once a week
High-risk condition	According to the member's need

Emergency services

The Department of Human Services defines an Emergency Medical Condition as “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

An emergency service is defined as covered inpatient and outpatient services that:

- Are furnished by a provider that is qualified to furnish such service under Title XIX of the Social Security Act
- Are needed to evaluate or stabilize an emergency medical condition

We’ll work with you to assure that members needing emergency services receive medically necessary treatment at appropriate levels in a timely manner.

Monitoring ED utilization

We closely monitor trends in emergency department (ED) utilization and implement appropriate interventions to address identified issues. PCPs are not contractually allowed to “sign out” to the ED or leave outgoing messages on their phone lines or with their answering services instructing members to go the emergency department for after-hours care.

We employ a variety of strategies to monitor and address emergency departmentutilization, including:

- Reviewing claims and other relevant data to monitor utilization patterns
- Educating providers and members about the appropriate use of the emergency department
- Making referrals to Case Management for evaluating a member’s access to care
- Ensuring behavioral health crisis intervention services are provided in the most appropriate setting (in collaboration with the BH-MCOs)
- Monitoring and profiling the accessibility of PCPs whose members have a high ED utilization trend

Our Case Management staff generates and reviews the following reports:

- High utilizing members (e.g., top 100 members with the highest utilization)
- ED visits by member and by primary care practitioner (PCP)
- ED visits by referring PCP groups
- ED visits by diagnosis, including those with primary mental health and substance abuse diagnoses as well as co-occurring disorders

Our Care Management staff uses these reports to track and trend information and identify potential over-utilization patterns, including:

- Identifying providers who may be driving inappropriate use of emergency department services (e.g., signing out with a message to their patients to go to the emergency department with any after-hours problems or those who lack urgent, same-day appointment availability)
- Identifying members who are frequent utilizers of emergency department services for non-emergent conditions and situations and informing PCPs about their patients' utilization of the ED (e.g., otitis media)
- Identifying hospitals that have high utilization or regular follow-up arranged through the ED

If needed, we can develop and implement corrective action plans, including one-on-one visits with providers and members.

We'll work collaboratively with providers to address issues that may affect ED utilization, such as prescribing patterns (e.g., asthma controller and rescue medications). Our Medical Management staff may also conduct educational sessions for either an individual or larger group of providers who we have identified as contributing to excessive ED utilization. Also, we may require a provider to attend a special training session and/or to develop a Corrective Action Plan.

Member Restriction Program

The Department's Bureau of Program Integrity (BPI) manages a centralized Member Restriction Program (also known as Recipient Restriction Program) for all managed care and Fee-For-Service delivery systems. We maintain a Member Restriction Program that interfaces with the centralized program and cooperates with the Department in all procedures. The program identifies, restricts and monitors members who have been determined to be abusing and/or misusing MA services or who may be defrauding the HealthChoices program. With the approval of the Department, members may be restricted to receiving services from a single, designated provider for a period of five years.

Our Prior Authorization Department monitors and evaluates the utilization of members whoare referred to the Member Restriction Program. You'll receive notification of members who are restricted.

Restrictions are enforced through the claims payment system. We may not pay for a service rendered by any provider other than the one to whom the member is restricted. The exception to this is if you provide services in response to an emergency or if you completed and submitted a Medical Assistance Member Referral Form (MA 45) with the claim. The MA 45 must be obtained from the practitioner to whom the member is restricted. If a member is restricted to a provider with your provider type, the EVS will notify you if the member is locked into you or another provider. The EVS will also indicate all type(s) or provider(s) to which the member is restricted. Valid emergency services are excluded from the lock-in process.

We obtain approval from the Department prior to implementing a restriction, including approval of written policies and procedures and correspondence to restricted members.

We will:

- Refer to the Department's Bureau of Program Integrity (BPI) those members identified as over utilizing or mutualizing medical services
- Evaluate the degree of abuse including review of pharmacy and medical claims history, diagnoses and other documentation, as applicable
- Propose whether the member should be restricted to obtaining services from a single, designated provider for a period of five years
- Forward case information and supporting documentation to BPI for review to determine appropriateness of restriction and to approve the action
- Upon BPI approval, send notification via certified mail to member of proposed restriction, including reason for restriction, effective date and length of restriction, name of designated provider(s) and option to change provider, with a copy to BPI
- Send notification of member's restriction to the designated provider(s) and the County Assistance Office
- Enforce the restrictions through appropriate notifications and edits in the Claims Payment System
- Prepare and present case at a DHS Fair Hearing to support restriction action
- Monitor subsequent utilization to ensure compliance
- Change the selected provider per the member's or provider's request within 30 days fromthe date of the request, with prompt notification to BPI through the Intranet provider change process
- Continue a member restriction from the previous delivery system as a member enrolls in the Managed Care Organization, with written notification to BPI
- Review the member's services prior to the end of the five-year period of restriction to determine if the restriction should be removed or maintained, with notification of the results of the review to BPI, member, provider(s) and County Assistance Office
- Perform necessary administrative activities to maintain accurate records
- Educate members and providers to the restriction program, including explanations in handbooks and printed materials

Member right to appeal

Members have the right to appeal a restriction by requesting a DHS Fair Hearing. Members cannot file a complaint or grievance with us regarding the restriction action. A request for a DHS Fair Hearing must be in writing, signed by the member and sent to: Department of Human Services, Office of Medical Assistance Programs of Bureau of Program Integrity Division of Program and Provider, Compliance: Member Restriction Section, P.O. Box 2675, Harrisburg, Pennsylvania 17105-2675, Phone: **717-772-4627**.

Chapter 10

Quality Management Overview

Quality Management (QM) is an ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care and service. This methodology is used by professional health personnel that review the degree of conformance to desired medical standards and practices and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.

Our Quality Assurance and Performance Improvement (QAPI) program is a continuous quality improvement (QI) 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/QI process enables us to:

- Assess current practices in both clinical and non-clinical areas
- Identify opportunities for improvement
- Implement Rapid Cycle Improvement activities
- 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 encounter data, ad-hoc internal reports, member and provider complaint data, HEDIS, EQR and CAHPS in the monitoring, measurement and evaluation of quality and appropriateness of care and services is an integral component of our quality improvement process.

Our QAPI program uses an integrated and collaborative approach, involving our entire senior management team, all functional areas within the health plan and all committees from the Board of Directors to the Health Education and Member.

Advisory subcommittee. Our Chief Medical Officer (CMO) oversees the QAPI program. The CMO is supported in this effort by our QM Department and the Quality Management and Utilization Management (QM/UM), Service Improvement (SIC), Credentialing, Appeals/Grievance and Delegation Subcommittee and Quality Management Oversight (QMOC) Committees.

Our QM staff, under the direction of the CMO, develops and implements an annual workplan, which specifies projected Quality Management activities.

Based on the work plan, we conduct an annual QAPI program evaluation. We encourage you to participate in medical committees and quality projects. If you wish to participate, call your Provider Relations Representative.

Our Quality Management department is an integral part of both Medical Management and internal operations. Through our team of Quality Management professionals, our focus is to

review and trend services and procedures for compliance with nationally recognized standards and to recommend and promote improvements in the delivery of care and service to our members. Our QM, UM and Special Needs Unit (SNU) maintain ongoing coordination and collaboration regarding Quality Initiatives, Care Management and Disease Management activities involving the care of special needs populations.

Our Quality Management includes, but is not limited to, medical record reviews, site reviews, peer reviews and provider profiling. Utilizing these tools, we, in collaboration with all participating health providers, are able to monitor and reassess the quality of care and services provided to our members.

Our highly effective Utilization Management (UM) program manages monitors, evaluates and improves the care and services provided to our members.

Our UM program is designed to:

- Educate members and providers about the appropriate utilization of care/service delivery systems
- Assess member and provider satisfaction with the processes
- Identify opportunities to optimize members' health outcomes
- Educate regarding the Pay for Quality program for eligible practices
- Identify opportunities to optimize members' health outcomes
- Manage health care costs

Our UM program is integrated with our Quality Management program, both of which are dedicated to ensuring high quality, cost-effective, outcome-oriented health care for our members.

Quality Practice Liaison program

Our Quality Practice Liaisons (QPLs) within the Quality Management department are your single point of contact regarding quality matters. QPLs collaborate with Network Relations Consultants to ensure the delivery of a seamless experience for our providers. Some QPL responsibilities include:

- Educate on requirements of key quality measures and programs which include HEDIS, state specific performance measures and Pay for Quality.
- Educate on appropriate coding for care capture. Administrative data capture reduces the burden of medical record review.
- Provide current gaps in care reports for key HEDIS measures and assistance on how to close existing care gaps.
- Educate regarding the Pay for Quality program for eligible practices.

Identifying opportunities for improvement

We effectively identify and evaluate opportunities for quality improvement. We determine the best intervention strategies through the systematic collection, analysis and review of a broad range of external and internal data sources. We identify opportunities for improvement by monitoring the following types of data:

Formal feedback from external stakeholder groups – We take the lead on reaching out to external stakeholder groups by conducting one-on-one meetings, satisfaction surveys (CAHPS) or focus groups with individuals such as members and families, providers, state and community agencies.

Findings from external program monitoring and formal reviews – As a result of externally initiated review activities such as an annual external quality program assessment or issues identified through a state's ongoing contract monitoring oversight process, we're made aware of specific program activities/processes needing improvement.

Internal review of individual member or provider issues – In addition to receiving complaints and grievances and appeals from members, providers and other external sources, we proactively identify potential quality of care issues for review through daily operations (e .g ., Member Services, Prior Authorization and Care Management). Through established formalized review processes (e .g ., grievances, appeals and quality of care), we're able to identify specific opportunities for improving care delivered to individual members.

Findings from internal program assessments – We conduct a number of formal assessments/reviews of program operations and subcontractors that are used to identify opportunities for improvement. This includes but is not limited to: ambulatory medical record reviews of contracted providers, credentialing/recredentialing of providers, oversightreviews of delegated activities, inter-rater reliability audits of medical review staff, annual Quality Management program evaluation, cultural competency assessment and assessmentof provider accessibility and availability.

Clinical and non-clinical performance measure results – We use an array of clinical and non-clinical performance standards including but not limited to HEDIS and Pennsylvania- specific performance measures call center response times, claim payment statistics and satisfaction surveys to monitor and evaluate member outcomes. Through frequent monitoringand trending of our performance measure results, we are able to identify and act upon opportunities for improvement in clinical and operational functions.

Data trending and pattern analysis – With our innovative information management systems and data mining tools, we make extensive use of data trending and pattern analysis for the identification of opportunities for improvement.

Performance Improvement Projects (PIPS)

Performance Improvement Projects (PIPs), a key component of our QAPI program, are designed to achieve and sustain a demonstrable improvement in the quality or appropriateness of services over time. All our PIPs follow CMS protocols.

We participate in state-mandated PIPs and select PIP topics that:

- Target improvement in areas that will address a broad spectrum of key aspects of member care and services over time
- Address clinical or non-clinical topics (e.g., care of acute conditions, member and provider satisfaction)
- Identify quality improvement opportunities through one or more of the identification processes described above
- Reflect our plan enrollment in terms of demographic characteristics, prevalence of disease, disparities and potential consequences (risks) of the disease

Our QM Department prepares PIP proposals that are reviewed and approved by our CMO, the QM/UM Committee and the QMOC prior to submission to the Department 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, as well as from network providers who are members of our QM/UM 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, we immediately employ Rapid Cycle Improvement techniques and conduct additional analyses 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.

Credentialing

All contracted health professionals are required to be credentialed by Aetna Better Health with the exception of pathologists, anesthesiologists, radiologists, emergency medicine and hospital-based providers.

Before rendering services, you must be credentialed with us. In addition, all providers must be enrolled with the Department of Human Services in the Medical Assistance program with an active, valid PROMISe ID.

New providers joining with a newly contracted practice will receive a credentialing application as part of their initial contract packet. New providers joining an existing contracted practice should submit an application as soon as they begin working at that location. Physicians and certain other health professionals are responsible for the completion of our credentialing

application and for providing all supplemental documentation required. All new providers, including providers joining an existing participating practice with Aetna Better Health, must complete the credentialing process. They must also be approved by our Credentialing Committee and governing body as the final phase of their contract. Physicians and certain other health professionals need to have a site visit completed by our Provider Relations Department before we can complete the credentialing process. Established providers will be re-credentialed at least every three years. If any documents (e.g., license, insurance, DEA, etc.) expire before the recredentialing period, you must forward the updated documents to our Credentialing department.

Other health professionals need to have a site visit completed by our Provider Relations Department before we can complete the credentialing process.

Established providers will be recredentialed at least every three years. If any documents (e.g., license, insurance, DEA, etc.) expire before the recredentialing period, you must forward the updated documents to our Credentialing Department.

The Aetna Credentialing and Performance Committee is responsible for the review of the professional credentials and profile data of potential participating health professionals, facilities and certain allied health professionals. For contracted providers, profile data is reviewed along with credentials.

Physician profiles

We profile all providers who meet the minimum threshold of members in their practices, as well as the minimum threshold of members for each profiling measure. We profile all providers and all practices for multiple measures compared with their own colleagues in their specialty. Also, we profile providers to assess adherence to evidence-based guidelines for their patients enrolled in Disease Management.

We designed the Provider Profiling program to share standardized utilization data with physicians in an effort to improve the utilization and health outcomes of members. Physicians often have little access to information about how they are managing patients or about how practice patterns compare to those of their peers. The overall goal is to reduce variation in care delivery and improve efficacy of care.

The indicators that we measure in the Provider Profile include, but are not limited to:

- Frequency of individual patient visits to the PCP
- EPSDT/Bright Futures services for the pediatric population
- HEDIS-type screening tests and evidence-based therapies (e.g., appropriate management of asthma linked with correct use of inhaled steroids)
- Use of medications
- ED utilization and inpatient service utilization

Semi-annually, we distribute profile reports to each practice and provider so they can evaluate:

- Potential gaps in care and opportunities for improvement
- Information relating to specific cares
- A snapshot of their overall practice

In addition, gaps-in-care reports are available via our secure provider portal. Contact your Quality Practice Liaison or Network Relations Consultant to learn how to access these reports.

Our CMO and medical directors regularly visit individual network providers to interpretprofile results, review quality data and discuss any new medical guidelines.

Peer review

The Credentialing and Performance Committee evaluates Peer Review Activities. You can appeal the Committee's recommendation if you get a review and disagree with the results. All you have to do is submit written appeals stating the reasons you disagree with the results.

We encourage physician participation on key QM/UM Committees. You can contact the Chief Medical Officer or inform your Provider Relations Representative if you wish to participate.

Major functions of the QM/UM Committee include:

- Review and evaluate the results of quality improvement activities
- Review and approve studies, standards, clinical guidelines, trends in quality and utilization management indicators and satisfaction surveys
- Recommend policies for development, review and approval

Ambulatory medical records review

Our standards for medical records exceed the medical record keeping requirements referenced in 55 Pa. Code Section 1101.51 (d)(e) of the MA Manual and medical record keeping standards adopted by DOH. We adopted standards from the NCQA and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within our provider network. Following is a list of our criteria for documentation of Care Medical Record Review. Our Quality Management Initiatives require consistent organization and documentation in patient medical records to assure continuity and effective, quality patient care.

Medical records may be on paper or electronic. Records must be maintained in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review.

Records will be readily available for review and copying by state and federal officials or their authorized agent at the provider's place of business or upon written request and shall be forwarded without charge to the Department of Human Services. If you are subject to an annual audit, you must submit your cost reports within 90 days following the close of the requested

fiscal years. If the Department of Human Services terminates its written agreement with a provider, the records relating to services up to the effective date of the termination remain subject to the requirements stated in this section. We refer you to your contract agreement concerning the requirement to make available upon request at no cost to Aetna Better Health, copies of member medical records.

Records, including both medical and fiscal types that fully disclose the nature of services rendered to members and that meet the criteria established in 55 Pa. Code Section 1101.51 (d)(e), will be retained for at least four years, unless otherwise specified in the provider regulations. The standards for records are as follows:

1) **Medical records standards** – Records must reflect all aspects of patient care, including ancillary services. We have set the following standards for medical records:
   a. **Patient identification information** – Each page or electronic file in the recordcontains the patient's name or patient ID number.
   b. **Personal/biographical data** – Personal/biographical data includes age, sex, address, employer, home and work telephone numbers and marital status.
   c. **Entries** – All entries will be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel shall be countersigned by the responsible licensed provider. Alterations of the record will be signed and dated.
   d. **Provider identification** – All entries are identified as to author.
   e. **Legibility** – The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer.
   f. **Allergies** – Medication allergies and adverse reactions are prominently noted on the record . Absence of allergies (no known allergies – NKA) is noted in an easily recognizable location.
   g. **Past medical history** – For patients seen by you and/or other providers in your practice three or more times in a two-year period, past medical history is easily identified including serious accidents, operations and illnesses. For children, past medical history relates to prenatal care and birth.
   h. **Immunizations** – For pediatric records (under 14 years of age) there is a completed immunization record or a notation that immunizations are up to date.
   i. **Diagnostic tests and results** – Documentation of medical necessity of rendered, ordered and prescribed services.
   j. **Therapies, medications and other prescribed regimens** – Drugs prescribed as part of the treatment, including quantities and dosages, shall be entered into the record. If a prescription is telephoned to a pharmacist, the prescriber's record shall have a notation to the effect.
   k. **Treatment plan** – Progress and changes in treatment plan are documented.

l. **Identification of current problems** – The record shall 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.

m. **Smoking/ETOH/substance abuse** – Notation concerning cigarettes and alcohol use and substance abuse is present for patients 12 years and over and seen three or more times in a two-year period.

n. **Consultations, referral and specialist reports** – Notes from consultations are in the record. Consultation, lab and x-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record and follow-up plans.

o. **Emergency care**.

p. **Hospitalizations**.

q. **Reports of operative procedures and excised tissues**.

r. **Hospital discharge summaries/disposition of the care** – Discharge summaries are included as part of the medical record for (1) all hospital admissions that occur while the patient is enrolled in Aetna Better Health, and (2) prior admissions as necessary.

s. **Referrals and results thereof**.

t. **All other aspects of patient care**.

u. **Advance Directives** – For medical records of adults, the medical record documents whether or not the individual has executed an Advance Directive. An Advance Directive is 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.

v. **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. This may include, but not limited to, purchase invoices, prescriptions, the pricing system used for services rendered to patients who are not MA members, either the originals or copies of Departmental invoices and records of payments made by other third-party payers.

w. **Additional record keeping requirements for providers in a shared health facility** – Practitioners and purveyors in a shared health facility shall meet the requirements set forth in 55 Pa. Code Section 1101.51(d)(e).

2) **Patient visit data** – Documentation of individual encounters must provide adequate evidence of, at a minimum:

   a. History and physical examination – Appropriate subjective and objective informationis obtained for the presenting complaints

   b. Treatment plan

   c. Diagnostic tests

   d. Therapies and other prescribed regimens

   e. **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 PRN; unresolved problems from previous visits are addressed in subsequent visits

   f. Referrals and results thereof

   g. All other aspects of patient care, including ancillary services

The purpose of the review is to verify that medical records of contracted family practice, internal medicine, general practice, obstetric and pediatric physicians comply with established DHS, NCQA and Aetna Better Health medical record keeping standards. Also, OB/GYN specialists must comply with ACOG standards. We review records for completeness of documentation, coordination of care and evidence of appropriate health maintenance screenings.

Penalties for noncompliance

The Department of Human Services may terminate its written agreement with a provider for noncompliance with the record keeping requirements of 55 Pa. Code Section 1101.51(d)(e) or for noncompliance with other record keeping requirements imposed by applicable federal and state statutes and regulations.

HEDIS requirements

The Department of Human Services requires that we produce Healthcare Effectiveness Data and Information Set (HEDIS) rates for all Medicaid reporting measures, with the exception of some of the behavioral health measures. HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) designed to reliably compare health plan performance.

HEDIS performance measures include areas such as:

- Prevention and screening
- Diabetes, musculoskeletal and behavioral health conditions
- Medication management care and coordination
- Respiratory and cardiovascular conditions
- Health plan descriptive information
- Overuse, appropriateness and cost of care

We work with providers to assure that all DHS requirements concerning HEDIS performance measures are met on an ongoing basis, including:

- Producing rates for Medicaid reporting measures as required by DHS.
- Following NCQA specifications as outlined in the HEDIS Technical Specifications, clearlyidentifying the numerator and denominator for each measure.

All HEDIS results are validated by an NCQA-licensed vendor .

We assist with the HEDIS validation process by the Department's NCQA-licensed contractor and submit validated HEDIS results annually to the Department of Human Services. We then incorporate HEDIS results into the annual overall Quality Improvement Plan.

Health care providers must supply copies of records within 14 calendar days of the receipt of a request, where practicable and in no event later than the date required by any applicable law, regulatory authority or government agency with jurisdiction over Aetna Better Health's operations (a "Government Sponsor"). Except as required by applicable state or federal law, Aetna Better Health (including Aetna Better Health's authorized designee), Government Sponsors and Aetna Better Health members shall not be required to reimburse providers for expenses related to providing copies of patient records or documents.

Refer to your Provider Agreement for the requirement to provide medical records upon request .

Consumer Assessment of Healthcare Providers and Systems

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 Child) are reporting required by the Department of Human Services. We contract with an NCQA-certified vendor to administer both the adult and child the survey according to NCQA survey protocols. The survey is based on randomly selected members and summarizes satisfaction with the health care experience.

In addition to the Adult survey, NCQA incorporates a CAHPS survey of parental experiences with their children's care. The separate survey is necessary because children's health care frequently requires different provider networks and addresses different consumer concerns (e .g . child growth and development). We submit results of the adult and child CAHPS survey to the NCQA in accordance with accreditation protocols.

External Quality Review (EQR)

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1902(a), (30), (c). The requirement mandates states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with Managed Care Organizations. The annual review includes the evaluation of quality outcomes, timeliness and access to services. 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.

We cooperate fully with external clinical record reviews assessing our network's quality of care, access to care and timeliness of care, as well as any other studies determined necessary by the Department of Human Services. We assist in the identification and collection of any data or clinical records to be reviewed by the independent evaluation team members. We also provide complete medical records to the External Quality Review Organization (EQRO) in the timeframe allowed by the EQRO. You may be asked to provide copies of member medical records at no cost to support the collection of data for Pennsylvania EQRO on behalf of the DHS. Refer to your Provider Agreement for the requirement to provide medical records upon request.

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

Chapter 11

Provider Incentive programs

Pay-For-Quality program (P4Q)

We fully recognize the value of structuring financial incentives to promote improvements in the delivery of effective health care services. We also know that there is a proven track record of successfully implementing pay for quality/performance (P4P/P4Q) programs that reward improvements in both processes and outcomes. P4P/P4Q initiatives include those with financial rewards, as well as those that develop partnerships with physician groups with the sole objective of improving health care outcomes. We will participate in the HealthChoices P4P as funded and allowed by contract.

Monitoring provider performance

We closely monitor clinical, service, quality and utilization factors to determine which providers are demonstrating best practices. Our experience has taught us that there are always providers whose practice profiles statistically reflect a level of service utilization above the norm. In the case of physicians who care for members with complex medical and/or behavioral health needs, these patterns may be completely expected and justified. The factors that we measure in developing provider profiles include, but are not limited to, the following:

- Frequency of individual patient visits
- Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT/Bright Futures) measures
- HEDIS measures
- Prescribing patterns
- Member complaints and grievances
- Provider complaints and appeals
- Emergency department and inpatient service utilization
- Adherence to evidence-based practice guidelines

We distribute provider profile results to individual providers and practitioners to enable them to evaluate their performance against their peers and identify potential gaps in care and opportunities for improvement. The profiles are available online via our secure provider portal. Also, if our Medical Management staff identifies a provider whose performance deviates significantly from the norm for his or her specialty, we will perform outreach and, if needed, require the implementation of a corrective action plan.

Chapter 12

Advance Directives (The Patient Self-Determination Act) Overview

The Patient Self-Determination Act of 1990, effective December 1, 1991, requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult members written information about the member's right to have an Advance Directive. An Advance Directive is a legal document through which a member may provide directions or express preferences concerning his or her medical care and/or to appoint someone to act on his or her behalf. Members can use Advance Directives when the member is unable to make or communicate decisions about his or her medical treatment. Advance Directives are prepared before any condition or circumstance occurs that causes the member to be unable to actively make a decision about his or her medical care.

In Pennsylvania, there are two types of Advance Directives:

- Living will or health care instructions
- Appointment of a health care power of attorney

Provider responsibility

Providers must comply with federal and state laws regarding Advance Directives (also known as Health Care Power of Attorney and Living Wills). Providers must also comply with contractual requirements for adult members. Also, we require that providers obtain and maintain Advance Directive information in the member's medical record. Requirements for providers include:

- Maintaining written policies that address a member's right to make decisions about their medical care, including the right to refuse care
- Providing members with written information about Advance Directives
- Documenting the member's Advance Directives or lack of one in his or her medical record
- Communicating the member's wishes to attending staff in hospitals or other facilities
- Not discriminating against a member or making treatment conditional on the basis of his or her decision to have or not have an Advance Directive
- Providing staff education on issues related to Advance Directives

Members can file complaints or grievances concerning noncompliance with Advance Directive requirements with Aetna Better Health/Aetna Better Health Kids or with the Pennsylvania Department of Human Services .

We provide information about Advance Directives to members in the Member Handbook, including the member's right to make decisions about their medical care, how to obtain assistance in completing or filing a living will or health care power of attorney and general instructions.

For more information or complaints regarding noncompliance with Advance Directive requirements, contact: Pennsylvania Office of Attorney General, Strawberry Square, 16thFloor Harrisburg, PA 17120, **717-787-3391**.

Chapter 13

Encounters, billing and claims

Billing instructions
Aetna Better Health uses our business application system to process and adjudicate claims. Both electronic and paper claims submissions are accepted.

To assist us in processing and paying claims efficiently, accurately and timely, we encourage providers to submit claims electronically. To facilitate electronic claims submissions, we have developed a business relationship with Change Healthcare and Office Ally. Aetna Better Health receives electronic data interchange (EDI) claims directly from these clearinghouses, 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 24 hours of file receipt, we provide production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

PROMISe ID number requirements

All providers who provide services to HealthChoices members must be enrolled in the commonwealth's Medical Assistance (MA) program and possess an active PROMISe provider ID in order to bill for services. MA providers who order, refer and prescribe are required to possess an active PROMISe provider ID. For information on how to enroll in PROMISe and enrollment forms, please visit the DHS's website at **www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx**.

Practitioners who provide services to Aetna Better Health members must be enrolled in Promise Fee-for-Service (FFS) Medical Assistance (MA).

All service locations enrolled in the MA program must revalidate including group enrollments as noted in DHS Provider Quick Tips #198.

To re-enroll, please submit, as soon as possible, a revalidation application (or reactivation application if you are submitting via the Electronic Provider Enrollment Portal). You can find specific instructions and further information at **www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx**.

Ordering, referring and prescribing requirements

DHS has implemented the ACA provision which requires that physicians and other practitioners that order, refer or prescribe items or services to MA beneficiaries be enrolled as participating providers.

Claims will deny if the ordering, referring or prescribing provider is not enrolled in the MA program.

Providers who order, refer or prescribe items or services to MA beneficiaries and are not currently enrolled in the MA program should access the DHS website for information on how to complete and submit the enrollment application that corresponds to the provider's type. DHS has implemented an electronic provider application to help streamline the enrollment application process.

More information can be found at **www.dhs.pa.gov/docs/Publications/Documents/FORMS-AND-PUBS-OMAP/c_224393.pdf**.

Member eligibility verification

An MA identification card, titled Pennsylvania ACCESS card, is an identification card issued by the Department of Human Services to each MA member. The card may be used by MA-enrolled providers to access the department's EVS and verify the member's MA eligibility and specific covered benefits. Prior to rendering or billing for services, verify each member's eligibility for benefits through the online eligibility information from the Eligibility Verification System (EVS). The EVS offers Medicaid providers the information to make an informed decision prior to rendering a service or item. For more information regarding the EVS and ways to access eligibility data, visit **www.dhs.pa.gov/providers/Quick-Tips/Documents/The-Eligibility-Verification-System-(EVS).pdf**.

Payment for medically necessary services for Medical Assistance members

In accordance with Pennsylvania Code 55, Chapter 1101, the Department of Human Services will only pay for Medically Necessary services for covered benefits. A service or benefit is medically necessary if it is compensable under the Medical Assistance program AND if it meets any one of the following standards:

- The service or benefit will or is reasonably expected to, prevent the onset of an illness, condition or disability
- The service or benefit will or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability
- The service or benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age

Determination of Medically Necessary 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/caretaker and the primary care practitioner, as well as any other providers, programs or agencies that have evaluated the member. All medical necessity determinations must be made by qualified and trained health care providers. A health care provider who makes such determinations of medical necessity is not considered to be providing a health care service under this agreement.

Encounters and claims

Aetna Better Health is required to submit to the Department of Human Services all necessary data that characterizes the covered health care service provided to a member.

- Aetna Better Health is required to process claims in accordance with Medicare and Medicaid claim payment rules and regulations.
- Providers must use valid International Classification of Disease, 9th 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 subclassification for that subcategory and assign the fifth-digit subclassification code for those subcategories 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 and reported.

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

Billing and claims co-payments

Certain services require a member co-payment. You should collect this amount from the member and deduct it from the amount billed to us.

You must submit all claims whether or not the member made full payment. You cannot deny services to the member even if the member hasn't made full payment of their cost-sharing amounts. It's important to document on the claim submitted the amount that the member paid or the amount you billed to the member.

Billing of members

You cannot balance bill members for any amounts exceeding the contractual allowance specified in the provider agreement. All providers are prohibited from billing members beyond the member's cost sharing liability, if applicable, as defined in the patient's benefits.

You cannot balance bill patients for covered services. You only bill patients for:

- Non-covered services
- Services that have not been authorized
- Services that are out-of-network

You can only bill patients for those services if you told the patient before rending the service that it's not covered and they agree in writing to pay the cost. You can bill members for their applicable Medical Assistance copayments. However, you cannot bill members for Medicare deductibles or coinsurance.

Coordination of benefits/third party

We are the primary payer on the following services:

- Preventive care
- Prenatal or preventive pediatric care (including EPSDT/Bright Futures services to children) and services to children having medical coverage under a Title IV-D child support order

For HealthChoices, we're the payer of last resort on all other services.

You must bill third-party insurance before submitting a claim to us. We'll pay the difference between the primary insurance payment and the Aetna Better Health allowable amount. You cannot balance bill members.

If the primary insurance carrier denies the claim as a non-covered service, you can submit the claim with the denial to us for a coverage determination under the member's program.

It is your responsibility to get the primary insurance carrier's explanation of benefits (EOB) or the remittance advice for services rendered to members that have insurance in addition to HealthChoices. The primary carrier's EOB or remittance advice should accompany any claims submitted for payment. A detailed explanation of how the claim was paid or denied should be included if not evident from the primary carrier's EOB or the remittance advice. This information is essential in order for us to coordinate benefits.

If a service is non-covered or benefits have been exhausted from the primary carrier, you must get an updated letter every January and July to submit with each claim. In most cases, we will deny claims submitted without the EOB for members where third party insurance is indicated.

In the event we pay a claim and later discover the member has other insurance, we'll recover the payment made to the provider.

If you need help with the billing of third-party payers, call Provider Relations at **1-866-638-1232**.

To prevent denials for coding mismatches, claims submitted to the primary carrier on a form that differs from our requirements should be clearly marked with COB Form Type Conversion.

Prenatal services

Effective April 1, 2019, Aetna Better Health will cost avoid claims for prenatal services. If there is a third-party resource, providers are to utilize the third-party resource prior to submitting a claim for prenatal services. Claims submitted with a date of service on and after April 1, 2019, will deny if coordination of benefits cannot be verified. More information can be found at **www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP/c_287104.pdf**.

For CHIP members

Timely claim submission requirements

We require providers to submit claims within 180 calendar days from the date of service. Claims resubmissions must be received no later than 365 calendar days from the date of the Provider Remittance Advice or EOB if the initial submission was within the 180 calendar day time period, whether or not the initial claim was denied.

We require Clean Claim submissions for processing. A "Clean Claim" is defined as one that can be processed (adjudicated) without obtaining additional information from the providerof service or from a third party.

Claims payment timeframes

In compliance with state regulations applicable to Medicaid Managed Care Plans, we process Clean Claims in the following timeframes. These timeframes apply to the HealthChoices Program:

- 90% of Clean Claims must be adjudicated within 30 calendar days of receipt
- 100% of Clean Claims must be adjudicated within 45 calendar days of receipt
- 100% of all Clean Claims must be adjudicated within 90 calendar days of receipt

Claims payment timeframes for CHIP claims are as follows:

- 95% of Clean Claims must be adjudicated within 30 calendar days of receipt
- 100% of Clean Claims must be adjudicated within 90 calendar days of receipt

For both MA and CHIP programs, claims that are not paid within 45 calendar days are paid with interest in accordance with state regulations.

Acceptable claims submission types

We require all providers to use one of the following forms when submitting claims:

- A CMS-1500 02/12 (formerly CMS 1500 08/05) billing form is used to submit claims for all professional services including ancillary services and professional services billed by a hospital
- Hospital inpatient and outpatient services, dialysis services, nursing home room and board and inpatient hospice services must be billed on the CMS-1450 billing form

We will not process claims received on any other type of claim form.

Completing a CMS 1500 02/12 (Formerly CMS 1500 05/08)

The CMS 1500 02/12 (formerly CMS 1500 05/08) billing form is used to submit claims for all professional services. When submitting a CMS 1500 form, certain fields are required.

CMS-1500 documentation

Before submitting a claim, you should ensure that you include all required attachments.
All claims that involve other insurance or Medicare must be accompanied by an explanation of benefits (EOB) or a remittance advice that clearly states how the claim was paid or the reason for denial.

Completing the CMS-1450

The CMS-1450 form is used when billing for facilities services including hospital inpatient and outpatient services, dialysis services, nursing home room and board and inpatient hospice service.

CMS-1450 documentation

Inpatient, ED and outpatient hospital claims above a certain threshold require additional documentation, which may include the medical records and an itemized bill.

Completing an EDI Submission

Professional and institutional claims must be submitted in an ANSI X12-837 electronic format (current version).

EDI documentation

Coordination of benefit information can be submitted electronically. All other attachments must be submitted via paper through normal claims submission processes.

Refer to your contract for documentation requirements and/or to the provider specific billing sections of this manual.

Electronic billing
In an effort to streamline and refine claims processing and improve claims payment turnaround time, Aetna Better Health encourages providers to electronically submit claims through Change Healthcare or Office Ally.

Use our EDI payer number 23228, when submitting claims for both CMS 1500 and CMS-1450 forms.

Change Healthcare also offers verification that allows you to submit claims by visiting Change Healthcare at **changehealthcare.com**.

Before submitting a claim through your clearinghouse, please verify that your clearinghouseis compatible with Change Healthcare or Office Ally.

We strongly encourage the electronic filing of claims (EDI). Electronic billing:

- Eliminates the cost of sending paper claims
- Allows you to track each claim sent
- Minimizes clerical data entry errors
- Ensures faster processing and payment of claim

We have agreements with the EDI claim clearinghouses listed below. They have software that sends pre-edited CMS 1500 02/12 and CMS-1450 claims to our Claim Department for review.

Important points to remember:

- Aetna Better Health does not accept direct EDI submissions from its providers
- Aetna Better Health 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 compliance upon roll-out

EDI Clearinghouses
Office Ally™ – Offers a FREE full-service HIPAA-compliant web-based clearinghouse to health care providers. You can submit professional CMS-1500 and facility CMS-1450 claims to Aetna Better Health by using either:

- Your existing software to create and submit claims electronically
- Office Ally's Online Claim Entry Tool to manually create and submit claims electronically

Go to **cms.officeally.com** and click on "Products," then "Enroll Today." Or call **360-975-7000**, option 1 to speak to an Office Ally representative.

Paper Claims

We encourage providers to bill electronically but realize there are times where providersneed to submit claims on paper.

Paper claims can be submitted to:

Aetna Better Health Claims Submissions
P.O. Box 62198
Phoenix, AZ 85082-2198

Change Healthcare – Change Healthcare (formerly Emdeon) is a contracted vendor Aetna Better Health uses for electronic claim submission, processing and support. You can call customer support at **1-800-845-6592**.

If you file your claims electronically, please be aware that the claim receipt acknowledgment file that we return to the clearinghouse is the only accepted proof of timely filing. If you have questions about this, contact your vendor directly.

National provider identifier (NPI)

Your submitted claims must be in compliance with HIPAA regulations regarding national provider identifier (NPI) numbers and claim forms. Claims for the HealthChoices Program must also contain the provider PROMISe identification number. We will return any claims that are not in compliance.

Compliance

The CMS-1500 form contains fields for the NPI numbers:

- Field 17 or EDI equivalent loop and segment, requires the NPI of the referring physician,if appropriate
- Field 24J or EDI equivalent loop and segment, is available for the NPI number of the provider rendering service(s)
- Field 32 or EDI equivalent loop and segment, requires the NPI of the facility location if other than office
- Field 33 or EDI equivalent loop and segment, requires the billing provider's NPI number

The CMS-1450 form contains fields for the NPI numbers:

- Form CMS-1450 requires the NPI number of the billing provider in field 56 or EDI equivalent loop and segment
- The NPIs of the attending physician and the operating physician should be located in fields 76 and 77 or EDI equivalent loop and segment, respectively

If EDI claims are rejected, check with your vendor first. If you experience any issues with EDI claims, contact our Provider Relations Department at **1-866-638-1232**.

NPI/PROMISe ID enrollment and revalidation

The Affordable Care Act (ACA) requires states to revalidate the enrollment of Medicaid providers every five years. Aetna Better Health follows DHS requirements that participating providers revalidate your NPI and PROMISe IDs, along with your service locations, every five years. **Failure to complete the revalidation process may result in nonpayment of claims.**

Effective July 1, 2019, as required by the Affordable Care Act (ACA) and DHS, **all Medicaid and CHIP providers who render services for Medicaid or CHIP beneficiaries, must be enrolled with DHS and have a valid PROMISe identification number (PROMISe ID) for each service location at which a provider operates**. DHS uses the National Provider Identification (NPI) number and taxonomy submitted on claims to validate the enrollment of providers in PROMISe.

Additionally, we require all participating Medicaid and CHIP providers contracted with Aetna Better Health who provide services for Medicaid or CHIP beneficiaries and have not yet enrolled, to promptly enroll with Pennsylvania PROMISe for all service locations as soon as possible.

Remittance Advice and Electronic Fund Transfer (EFT)

Aetna Better Health 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 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 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 after this payment cycle. This will result in a negative amount paid.
- The check number 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 number 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.
- The 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
  - 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.

When submitting claims, we encourage our providers to utilize EDI, EFT and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Contact our Provider Services Department for assistance with this process. To enroll in EFT and ERA using Availity, our Provider Portal just visit: **AetnaBetterHealth.com/Pennsylvania/providers/forms.**

Virtual credit card

Aetna Better Health uses virtual credit cards to process provider payments. Instead of receiving paper checks for claims payments from us, virtual card payment information will be printed on your remittance advance (RA). RAs include a 16-digit card number which can be entered into your current point of sale (POS) terminal to accept the payment, similar to the manner in which you manually key in patient payments. Please note, your standard merchant fees will apply. The card information must be entered within the expiration date specified on your virtual card.

Enrollment in virtual credit card payment is automatic when you join our network. If you would like to opt out of this program and switch to electronic funds transfer (EFT), you must call **855-723-3475**. To sign up for EFT, follow the steps outlined in the EFT section below.

Electronic funds transfer (EFT)

You can direct funds to a designated bank account. Just visit our Availity secure web portal. Once you are registered you can enroll in EFT. The process takes about 30 days for EFT implementation.

To enroll in EFT, click on the link and go the the Electronic Fund Transfer (EFT)/Electronic Remittance Advice (ERA) Sign up tab online at **AetnaBetterHealth.com/PA/providers/forms**.

Claims resubmission

Aetna Better Health must receive claims resubmission no later than 365 calendar days from the date of the provider remittance advice or explanation of benefits if the initial submission was within the 180 calendar day time period whether or not the initial claim was denied.

You can resubmit:

1. Corrected claims
2. Previously submitted claims to which additional information has been attached

To ensure timely and accurate processing, corrected or resubmitted claims must be:

- Submitted within the contracted timely filing guidelines
- Submitted electronically through our electronic data interface (EDI) vendors when supporting documentation is not required
- Submitted on paper to our processing center when supporting documentation is required

When submitting a corrected claim, indicate on the claim whether it is a corrected claim or a resubmitted claim with appropriate supporting documentation. Providers can enter a claim resubmission form that includes required documentation via the secure web portal. Please note that this functionality is for claim resubmissions that include required documentation, not claim corrections or provider appeals.

Technical assistance

For technical assistance related to claims submissions, call Provider Relations at **1-866-638-1232**.

Claims inquiries

You can contact the Claims Inquiry Line from 8 AM to 5 PM EST each business day by calling**1-866-638-1232**. An automated telephone system allows you to speak directly with a representative or leave a detailed message regarding your inquiry. Our Claims Administration Department employs full-time claims inquiry and research representatives to respond to your questions, status inquiries and claims payment disputes. You can also check on claims status by logging on to the secure web portal.

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, excluding:
  - Corrections to prior authorization numbers – providers must call the Prior Authorization Department directly
  - Rebilling a claim – the entire claim must be resubmitted with corrections

Please be prepared to give the Claims 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

Written inquiries should be directed to the claims staff at Aetna Better Health, Attn: Claims Department, PO Box 62198, Phoenix, AZ 85082-2198.

Instruction for specific claims types

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 Pennsylvania Medicaid claim processing rules.

We periodically update our policies and claims payment systems to align with correct-coding initiatives, as well as these national benchmarks and industry standards:

- Centers for Medicare & Medicaid Services (CMS) guidelines
- American Medical Association (AMA) Current Procedural Terminology (CPT)
- Health Care Common Procedure Coding System (HCPCS)
- International Classification of Diseases, 9th Edition (ICD-9) and 10th Edition (ICD-10), depending on the claim's date of service

These updates support our continuing efforts to process claims accurately.

Provider facility code requirement

Effective June 1, 2019, when a service is provided in a facility and the provider is submittinga professional claim, the service facility information must be submitted. Specific claim requirements include:

- Facility NPI and address must be submitted for professional claims billed for services rendered at a facility POS 19, 21-24, 31 & 32
- The service facility location must be populated in Loop 2310C Segment NM109
- Service facility location name, address and nine digit zip in box 32 on the CMS1500
- Service facility location NPI in box 32a on the CMS 1500

If the facility location information is not included on the claim, the claim will deny. If the facility number is not numeric or is missing AND the place of service (POS) is 21 – InpatientHospital, 22 – Outpatient Hospital, 23 – Emergency Room, 24 – Ambulatory Surgical Center, 31 – Skilled Nursing Facility or 32 – Nursing Facility, then your claim will deny. If there are any services that are not actually done at the facility for a recipient, then the POS should not be 21, 22, 23, 24, 31 or 32.

Newborn billing guidelines

Under DHS guidelines, if there is no ID set up for a newborn at the time of the inpatient claim submission, the newborn must be submitted under the mother's ID.

Listed below are guidelines for billing newborns under the mother's ID:

- There must be no available ID for the newborn at the time of claim submission
- Newborn should be billed under mother's ID with the newborn's date of birth
- The newborn's date of birth should be **less than one year old** at the time of claim submission
- Claim must be billed with:
  - Admission Type 4
  - Condition Code YO

Skilled Nursing Facilities (SNF)

- Providers submitting claims for SNFs should use CMS-1450 form.
- Providers must bill in accordance with standard Medicaid requirement rules for Aetna Better Health of Pennsylvania. For additional information refer to Pennsylvania Medicaid website at **www.dhs.pa.gov/docs/For-Providers/Pages/Regulations-Handbooks-Guides-and-Manuals.aspx**.

Home health claims

- Providers submitting claims for home health should use a CMS 1500 form.
- For additional information refer to the Pennsylvania Medicaid website at **www.dhs.pa.gov/docs/For-Providers/Pages/Regulations-Handbooks-Guides-and-Manuals.aspx**.

Global Maternity Bundling

Global maternity care includes pregnancy-related antepartum care, admission to labor and delivery, management of labor including fetal monitoring, delivery, and uncomplicated postpartum care until six weeks postpartum.

Healthy Beginnings Plus (HBP) providers are allowed to submit total obstetric care using global codes. When billing total obstetric care providers should follow the requirements listed below:

- Any time HBP providers utilize a bundled code, including maternity bundled procedures, submission of the itemization of when those services occur is also required
- Providers must submit the actual Current Procedural Terminology (CPT) or Healthcare Common Procedural Coding System (HCPCS) code for the service rendered in addition to the global obstetric code to receive payment
- Effective January 1, 2020, the following global and bundled procedure codes must also be accompanied by an Evaluation & Management (E&M) code to reflect the actual date of antepartum and postpartum care: 59400, 59410, 59425, 59426, 59510, 59515, 59610, 59614 and 59618

Claims will be denied if only the global code is billed. Global maternity billing is for HealthyBeginnings Plus providers only. All other providers should continue billing fee-for-service.

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
- For additional information refer to the Pennsylvania Medicaid website at **www.dhs.pa.gov/docs/For-Providers/Pages/Regulations-Handbooks-Guides-and-Manuals.aspx**

Same-day readmission claims

- Providers submitting claims for inpatient facilities should use CMS-1450 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 24 hours.

Example: Discharge date: 10/2/10 at 11 AM / readmission date: 10/3/10 at 9 AM

- Since the readmission was within 24 hours, this would be considered a same-day readmission per above definition

Provider dispute and appeals resolution

We offer providers:

- An informal disputes process for expressing dissatisfaction with a decision that directly impacts the provider
- A formal appeals process to request reversal of a denial with regard to:
  - Provider credentialing
  - Network provider claims, including payment denial for services already rendered by the provider to a member
  - Provider Agreement termination by Aetna Better Health

We encourage you to resolve your post-service claims denial using the informal dispute processes prior to utilizing the formal provider appeals process. The Provider Relations supervisor and representatives will work with you to resolve disputes and provide education on how to access and utilize the Aetna Better Health informal dispute and formal appeal process.

Informal provider dispute

A dispute is a verbal or written expression of dissatisfaction concerning a decision that directly impacts the provider. Disputes are typically administrative and do not include decisions concerning medically necessary decisions. There are multiple avenues to resolve claims and other provider disputes. You can:

- Access our secure web portal
- Contact your assigned Provider Relations Representative
- Call the toll-free Claims Inquiry and Claims Research Unit at **1-866-638-1232**

The formal provider appeals process should only be used after other attempts to resolve the matter have failed through the informal dispute process.

You can contact the Provider Relations Department at **1-866-638-1232**, and/or contact your assigned Provider Relations Representative.

To submit information regarding your concern or dispute, send all documents to:
Aetna Better Health of Pennsylvania, Attention: Complaints, Grievances & Appeals,
PO Box 81040, 5801 Postal Rd, Cleveland, OH 44181

Formal provider appeals

You can request a reversal of an action related to:

- Provider credentialing
- Network provider claims, including payment denial for services already rendered by the provider to a member
- Provider Agreement termination by Aetna Better Health

Pre-service requests resulting in a prior authorization denial, reductions or terminations must follow the member complaint and grievance process. You must submit provider appeals within 60calendar days from the date of notification of claim denial unless otherwise specified within the provider contract.

For questions concerning the provider appeal process, contact the Provider Appeals Department by fax at **1-860-754-1757**.

To submit a formal provider appeal in writing, send to: Aetna Better Health of Pennsylvania, Attention: Complaints, Grievances & Appeals, PO Box 81040, 5801 Postal Rd, Cleveland, OH 44181.

Submission steps:

1. Submit the appeal in writing to Aetna Better Health to the address above 2.

State the factual basis for the relief requested

3. Include all supporting documentation with the appeal submission, such as: remittance advice(s), medical records and claims

Failure to specifically state the factual basis of the appeal and/or failure to submit support documentation may result in denial of the provider appeal.

We'll acknowledge a provider appeal within five business days after receipt. If you don't receive an acknowledgement letter within five business days, contact the Provider Appeals Department. Once received, the appeal will be reviewed and a decision will be rendered within 60 calendar days after receipt. We may request an extension of up 30 calendar days, if necessary.

Also, we have a Provider Clinical Appeals Committee to review and decide provider appeals. The decision of the Provider Clinical Appeals Committee is final. We send decision notification letters to the requesting provider within five business days of the committee decision. We will not take any punitive action against a provider for using the provider appeal process.

Reimbursement

We reimburse providers according to our fee schedule or other contracted rates. Your contract tells you the type of reimbursement you receive and the services you can provide. If you have questions, just call your Provider Relations Representative.

Chapter 14

Member complaints, grievances and DHS Fair Hearings Overview

The Complaints and Grievances Department has the overall responsibility for the management of the member complaint and grievance process for HealthChoices. This includes:

- Documenting individual complaints and grievances
- Coordinating resolutions
- Maintaining logs and records of the complaints and grievances
- Tracking, trending and reporting data

Our Complaint, Grievance and DHS Fair Hearing coordinator serves as the primary contact person for the complaint and grievance process.

The Complaints and Grievances Department, in collaboration with Member Services and Provider Relations, is responsible for:

- Informing and educating members and providers about a member's right to file a complaint or grievance or request a DHS Fair Hearing
- Assisting members in filing a complaint or grievance or in requesting a DHS Fair Hearing

We tell members about their complaint, grievance and DHS Fair Hearing rights and the complaint, grievance and DHS Fair Hearing process at the time of enrollment and at least annually thereafter. We provide this information to members via the member handbook, member newsletters and our website. The information includes, but is not limited to:

- The method for filing a complaint, grievance or for requesting a DHS Fair Hearing including procedural steps and timeframes for filing each level of a complaint or grievance or for requesting a DHS Fair Hearing
- Notification of member's rights related to complaints, grievances and DHS Fair Hearing, including the right to voice complaints or grievances about Aetna Better Health or care provided
- The availability of assistance from Aetna Better Health with filing a complaint, grievance or requesting a DHS Fair Hearing, along with a toll-free number and address for filing complaints, grievances or requesting a DHS Fair Hearing
- Upon request, reasonable assistance with the complaint, grievance and DHS Fair Hearing process is provided to members. This includes but is not limited to providing oral interpreter services and toll-free numbers with TTY/TDD and sign language interpreter capability. Our staff members are trained to respond to members with disabilities with patience, understanding and respect.

The Department of Human Services defines "complaint" and "grievance" as two separate and distinct types of issues. Members and their representatives, including providers, may file a complaint or grievance if they are not able to resolve issues through informal channels with Aetna Better Health or DHS. Members and their representatives may request a DHS Fair Hearing.

The Department of Human Services defines "complaint" as a dispute or objection regarding a participating health care provider or the coverage, operations or management policies of Aetna Better Health, which has not been resolved. In addition, the complaint has been filed with any of the following:

- Aetna Better Health of Pennsylvania
- The Department of Health
- The Pennsylvania Insurance Department of the Commonwealth

This definition does not include grievances.

Please note that this process only applies to HealthChoices Medical Assistance members. The process for CHIP members is the same with the exception that CHIP members do not have Standard Fair Hearing rights.

If a member is unhappy with or does not agree with something their provider or Aetna Better Health of Pennsylvania does, they can tell us or the Department of Human Services what they are unhappy about or that they disagree with. This section describes what members can do and what will happen.

Complaints

What is a complaint?
A complaint is when the member tells us they are unhappy with Aetna or their provider or do not agree with a decision by Aetna.

Some things the member may complain about:

- They are unhappy with the care they are getting
- They cannot get the service or item they want because it is not a covered service or item
- They have not gotten services that we have approved
- They were denied a request to disagree with a decision that they have to pay their provider

First Level Complaint
What should the member do if they have a complaint?

To file a first level complaint:

- The member should call us at **1-866-638-1232 (PA Relay: 711)** and tell us their complaint
- Write down their complaint and send it to Aetna Better Health of Pennsylvania by mail or fax
- If the member received a notice from Aetna Better Health informing them of our decision and the notice included a Complaint/Grievance Request Form, they should fill out the form and send it to us by mail or fax

You can file a complaint on a member's behalf if the member provides their consent in writing to do so. Send it to Aetna Better Health of Pennsylvania, Attention: Complaints, Grievances & Appeals Dept., PO Box 81139, 5801 Postal Rd, Cleveland, OH 44181, fax: **860-754-1757**.

When should a member file a First Level Complaint?

Some complaints have a time limit on filing. The member must file a complaint within 60 days of getting a notice telling them that Aetna Better Health:

- Has decided that the member cannot get a service or item that they want because it is not a covered service or item
- Will not pay the member's provider for a service or item they received
- Did not tell the member its decision about a complaint or grievance that the member told Aetna about within 30 days from when Aetna got the member's complaint or grievance
- Has denied the member's request to disagree with Aetna's decision that they have to pay their provider

The member must file a complaint within 60 days of the date that they should have gotten a service or item if they did not get a service or item. The time by which the member should have received a service or item is listed below.

The member may file all other complaints at any time.

New member for first examination	Appointment timeframes
Members with HIV/AIDS	With PCP or specialist no later than 7 days after the member joins Aetna Better Health unless they are already being treatedby a PCP or specialist.
Members who receive Supplemental Security Income (SSI)	With PCP or specialist no later than 45 days the member joins Aetna Better Health, unless they are already being treated by a PCP or specialist.
Members under the age of 21	With PCP for an EPSDT/Bright Futures exam no later than 45 days after the member joins Aetna Better Health, unless they are already being treated by a PCP or specialist.
All other members	With PCP no later than 3 weeks after the member joins Aetna Better Health.

Members who are pregnant	Appointment timeframes
Women in their first trimester	With OB/GYN provider within 10 business days of Aetna Better Health learning the member is pregnant.
Women in their second trimester	With OB/GYN provider within 5 business days of Aetna Better Health learning the member is pregnant.
Women in their third trimester	With OB/GYN provider within 4 business days of Aetna Better Health learning the member is pregnant.
Women with high-risk pregnancies	With OB/GYN provider within 24 hours of Aetna Better Health learning the member is pregnant.

Appointment with PCP	Appointment must be scheduled
Urgent medical condition	Within 24 hours
Routine appointment	Within 10 business days
Health assessment/general physical examination	Within 3 weeks

Appointment with a specialist	Appointment must be scheduled
When referred by PCP/urgent medical condition	Within 24 hours of referral
Routine appointment with one of the following specialists: • Otolaryngology • Dermatology • Pediatric Endocrinology • Pediatric General Surgery • Pediatric Infectious Disease • Pediatric Neurology • Pediatric Pulmonology • Pediatric Rheumatology • Dentist • Orthopedic Surgery • Pediatric Allergy & Immunology • Pediatric Gastroenterology • Pediatric Hematology • Pediatric Nephrology • Pediatric Oncology • Pediatric Rehab Medicine • Pediatric Urology • Pediatric Dentistry	Within 15 business days of referral
Routine appointment with all other specialists	Within 10 business days of referral

What happens after the member files a First Level Complaint?

After the member files their complaint, they will get a letter from us telling them that we have received their complaint and about the First Level Complaint review process.

The member may ask to see any information Aetna Better Health has about the issue thatthey filed their complaint about at no cost to the member. The member may also send information that they have about their complaint to Aetna Better Health.

The member may attend the complaint review if they wish to attend it. We will tell the member the location, date and time of the complaint review at least 10 days before the day of the review. The member may appear at the complaint review in person, by phone or by video conference. The member's attendance has no effect on the decision.

A committee of one or more Aetna Better Health staff members who were not involved in and do not work for someone who was involved in the issue the member filed their complaint about will meet to make a decision about the complaint. If the complaint is about a clinical issue, a licensed doctor will be on the committee. Aetna will mail the member a notice within 30 days from the date that they filed their First Level Complaint to tell them the decision on their First Level Complaint. The notice will also tell the member what they can do if they do not like the decision.

What to do to continue getting services

If the member has been getting the services or items that are being reduced, changed or denied and they file a complaint verbally or that is faxed, postmarked or hand-delivered within 10 days of the date on the notice telling them that the services or items they have been receiving are not covered services or items for the member, the services or items will continue until a decision is made.

What if the member does not like our decision?

The member may ask for an External Complaint review, a Fair Hearing, or an External Complaint review and a Fair Hearing if the complaint is about one of the following:

- Aetna Better Health's decision that the member cannot get a service or item they want because it is not a covered service or item
- Aetna Better Health's decision to not pay a provider for a service or item the member received
- Aetna Better Health's failure to decide a complaint or grievance the member told Aetna about within 30 days from when Aetna got the complaint or grievance
- The member not getting a service or item within the time by which the member should have received it
- Aetna Better Health's decision to deny the member's request to disagree with our decision that they have to pay their provider

The member must ask for an External Complaint review within 15 days of the date they received the First Level Complaint decision notice.

The member must ask for a Fair Hearing within 120 days from the mail date on the notice telling them the complaint decision.

For all other complaints, the member may file a Second Level Complaint within 45 days of the date they received the complaint decision notice.

Learn more about Fair Hearings.

Learn more about External Complaint review.

Learn more about help during the complaint process.

Second Level Complaint

What should the member do if they want to file a Second Level Complaint?

To file a Second Level Complaint

- The member can call Aetna Better Health at **1-866-638-1232** (**PA Relay: 711**) and tell us their Second Level Complaint
- The member can write down their Second Level Complaint and send it to us by mail or fax

The member can fill out the Complaint Request Form included in their complaint decision notice and send it to us by mail or fax: Aetna Better Health of Pennsylvania, Attention: Complaints, Grievances & Appeals, PO Box 81139, 5801 Postal Rd, Cleveland, OH 44181, fax: **860-754-1757**.

What happens after the member files a Second Level Complaint?
After the member files their Second Level Complaint, they will get a letter from us telling them that we have received their complaint and about the Second Level Complaint review process.

The member may ask to see any information Aetna has about the issue they filed in their complaint about at no cost to the member . The member may also send information that they have about their complaint to Aetna Better Health.

The member may attend the complaint review if they wish to attend it. We will tell the member the location, date and time of the complaint review at least 15 days before the complaint review. The member may appear at the complaint review in person, by phone or by video conference. The member's attendance review will not affect the decision.

A committee of three or more people, including at least one person who does not work for Aetna Better Health of Pennsylvania, will meet to decide the member's Second Level Complaint. The Aetna Better Health staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue the member filed their complaint about. If the complaint is about a clinical issue, a licensed doctor will be on the committee. Aetna Better Health will mail the member a notice within 45 days from the date their Second Level Complaint was received to inform them of the decision on their Second Level Complaint. The letter will also tell the member what they can do if they do not like the decision.

Learn more about help during the complaint process.

What if the member does not like our decision on the Second Level Complaint?
The member may ask for an external review by either the Department of Health or the Insurance Department. The member must ask for an external review within 15 days of the date they got the Second Level Complaint decision notice.

External Complaint Review

How does the member ask for an External Complaint Review?
The member must send their request for external review of their complaint in writing to either: Pennsylvania Department of Health Bureau of Managed Care, Health and Welfare Building, Room 912 625 Forster Street, Harrisburg, PA 17120-0701, **1-888-466-2787** or Pennsylvania Insurance Department Bureau of Consumer Services, Room 1209, Strawberry Square Harrisburg, Pennsylvania 17120, **1-877-881-6388**.

If the member asks, the Department of Health will help the member put their complaint in writing.

The Department of Health handles complaints that involve the way a provider gives care or services. The Insurance Department reviews complaints that involve Aetna Better Health's policies and procedures. If the member sends their request for external review to the wrong Department, it will be sent to the correct Department.

What happens after the member asks for an External Complaint Review?
The Department of Health or the Insurance Department will get the member's file from Aetna Better Health. The member may also send the Departments any other information that may help with the external review of their complaint.

The member may be represented by an attorney or another person such as their representative during the external review.

A decision letter will be sent to the member after the decision is made. This letter will tell the member all the reason(s) for the decision and what they can do if they do not like the decision

Continuation of services
If the member has been getting the services or items that are being reduced, changed or denied and their request for an External Complaint review is postmarked or hand-delivered within 10 days of the date on the notice telling them Aetna Better Health's First Level Complaint decision that they cannot get services or items that they have been receiving because they are not covered services or items for the member, the services or items will continue until a decision is made.

Grievances

What is a Grievance?
When Aetna Better Health of Pennsylvania denies, decreases or approves a service or item different than the service or item the provider requested because it is not medically necessary, the member will get a notice telling them about Aetna's decision.

A grievance is when the member tells us that they disagree with our decision.

What should the member do if they have a grievance?

To file a grievance:

- The member can call us at **1-866-638-1232 (PA Relay: 711)** and tell us their grievance
- The member can write down their grievance and send it to us by mail or fax to
- The member can fill out the Complaint/Grievance Request Form included in the denial notice they received from us and send it to us by mail or fax to:
  Aetna Better Health, Attn: Complaints, Grievances & Appeals, PO Box 81139, 5801 Postal Rd, Cleveland, OH 44181, fax: **860-754-1757**

You can file a grievance on behalf of the member if the member provides their consent in writing to do so. If you file a grievance on behalf of the member, the member cannot file a separate grievance on their own.

When should the member file a grievance?

The member must file a grievance within 60 days from the date they get the notice telling them about the denial, decrease or approval of a different service or item for the member.

What happens after the member files a grievance?

After the member files their grievance, they will get a letter from us telling them that we have received their grievance and about the grievance review process.

The member may ask to see any information that Aetna Better Health used to make the decision they filed their grievance about at no cost to the member. The member may also send information that they have about their grievance to us.

The member may attend the grievance review if they wish to attend it. Aetna Better Health will tell the member the location, date and time of the grievance review at least 10 days before the day of the grievance review. The member may appear at the grievance review in person, by phone or by videoconference. The member's attendance has no effect on the decision.

A committee of three or more people, including a licensed doctor, will meet to decide the member's grievance. Our staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue the member filed their Grievance about. Aetna Better Health of Pennsylvania will mail the member a notice within 30 days from the date their Grievance was received to tell the member the decision on their Grievance. The notice will also tell the member what they can do if they do not like the decision.

Learn more about help during the Grievance process.

Continuation of services

If the member has been getting services or items that are being reduced, changed or denied and the member files a Grievance verbally or that is faxed, postmarked or hand-delivered within 10 days of the date on the notice telling them that the services or items they have been receiving are being reduced, changed or denied, the services or items will continue untila decision is made.

What if the member does not like our decision?
The member may ask for an external Grievance review or a Fair Hearing or they may ask for both an external Grievance review and a Fair Hearing. An external Grievance review is a review by a doctor who does not work for Aetna Better Health.

The member must ask for an external grievance review within 15 days of the date they received the grievance decision notice.

The member must ask for a Fair Hearing from the Department of Human Services within 120 days from the date on the notice telling them the grievance decision.

Aetna Better Health, Attn: Complaints, Grievances & Appeals, PO Box 81139, 5801 Postal Rd, Cleveland, OH 44181, fax: **860-754-1757**.

Learn more about Fair Hearings.

Learn more about help during the grievance process.

If you need more information about external Grievance review, see below.

External Grievance Review
How does the member ask for External Grievance Review?

To ask for an external Grievance review:

- The member can call us at **1-866-638-1232 (PA Relay: 711)** and tell us their Grievance
- The member can write down their Grievance and send it to us by mail at Aetna Better Health, Attn: Complaints, Grievances & Appeals, PO Box 81139, 5801 Postal Rd, Cleveland, OH 44181

Aetna Better Health of Pennsylvania will send the member's request for external Grievance review to the Department of Health.

What happens after the member asks for an External Grievance Review?
The Department of Health will notify the member of the external Grievance reviewer's name, address and phone number. The member will also be given information about the external Grievance review process.

Aetna Better Health will send the member's Grievance file to the reviewer. The member may provide additional information that may help with the external review of their Grievance to the reviewer within 15 days of filing the request for an external Grievance review.

The member will receive a decision letter within 60 days of the date they asked for an external Grievance review. This letter will tell the member all the reason(s) for the decision and what they can do if they do not like the decision.

Continuation of services

If the member has been getting the services or items that are being reduced, changed or denied and they ask for an external grievance review verbally or in a letter that is postmarked or hand-delivered within 10 days of the date on the notice telling them of our grievance decision, the services or items will continue until a decision is made.

Expedited Complaints and Grievances

What can the member do if their health is at immediate risk?

If you believe that waiting 30 days (for the First Level Complaint or Grievance decision) or 45 days (for the Second Level Complaint decision) to hear a decision about the member's complaint or Grievance could harm the member's health, you or the member may ask that the member's complaint or Grievance be decided more quickly. For the member's complaint or Grievance to be decided more quickly:

- The member must ask Aetna Better Health for an early decision by calling us at **1-866-638-1232 (PA Relay: 711)**, faxing a letter or the Complaint/Grievance Request Form to **1-860-754-1757**, or sending an email to **pamedicaidappeals&grievance@aetna.com**
- You should fax a signed letter to **1-860-754-1757** within 72 hours of the member's request for an early decision that explains why Aetna Better Health is taking 30 days (for the First Level Complaint or Grievance decision) or 45 days (for the Second Level Complaint decision) to tell the member the decision about their complaint or grievance could harm their health

If we do not receive a letter from you (the provider) and the information provided does not show that taking the usual amount of time to decide the member's complaint or Grievance could harm their health, Aetna will decide the member's complaint or Grievance in the usual timeframe of 30 days (for the First Level Complaint or Grievance decision) or 45 days (for the Second Level Complaint decision) from when Aetna first got their complaint or Grievance.

Expedited Complaint and Expedited External Complaint

The member's expedited complaint will be reviewed by a committee that includes a licensed doctor . Members of the committee will not have been involved in and will not have worked for someone who was involved in the issue the member filed their complaint about.

The member may attend the expedited complaint review if they wish to attend it . The member can attend the complaint review in person but may have to appear by phone or by videoconference because Aetna Better Health has a short amount of time to decide an expedited complaint. The member's attendance at the expedited complaint or grievance review will not affect the decision.

We will inform the member of the decision within 48 hours of when we get the letter explaining why the usual timeframe for deciding the member's complaint will harm their health, or within 72 hours from when we get the member's request for an early decision,

whichever is sooner, unless the member asks us to take more time to consider their complaint. The member can ask Aetna Better Health to take up to 14 more days to decide their complaint. The member will also get a notice telling them the reason(s) for the decision and how to ask for expedited external complaint review, if they do not like the decision.

If the member did not like the expedited complaint decision, they may ask for an expedited external complaint review from the Department of Health within two business days from the date they get the expedited complaint decision notice. To ask for expedited external review of a complaint:

- The member can call Aetna Better Health at **1-866-638-1232** (**PA Relay: 711**) and tell Aetna their complaint
- The member can send an email to Aetna Better Health at **pamedicaidappeals&grievance@aetna.com**
- The member can write down their complaint and send it to Aetna Better Health by mail or fax to Aetna Better Health, Attn: Complaints, Grievances & Appeals, PO Box 81139, 5801 Postal Rd, Cleveland, OH 44181, fax: **860-754-1757**

Expedited Grievance and Expedited External Grievance

A committee of three or more people, including a licensed doctor, will meet to decide the member's Grievance. Our staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue the member filed their Grievance about.

The member may attend the expedited grievance review if they wish to attend it. The member can attend the grievance review in person but may have to appear by phone or by videoconference because Aetna has a short amount of time to decide the expedited Grievance. The member's attendance at the expedited grievance or expedited external grievance review will have no effect on the decision.

We will inform the member of the decision about their grievance within 48 hours of when we get your letter explaining why the usual timeframe for deciding the member's grievance will harm their health, or within 72 hours from when we get the member's request for an early decision, whichever is sooner, unless the member asks us to take more time to decide their grievance. The member can ask us to take up to 14 more days to decide their grievance. The member will also get a notice telling them the reason(s) for the decision and what to do if they do not like the decision.

If the member does not like the expedited grievance decision, they may ask for an expedited external grievance review or an expedited Fair Hearing by the Department of Human Services, or both an expedited external grievance review and an expedited Fair Hearing.

The member must ask for expedited external grievance review by the Department of Health within two business days from the date they received the expedited grievance decision notice. To ask for expedited external review of a grievance:

- The member can call Aetna Better Health at **1-866-638-1232 (PA Relay: 711)** and tell us their grievance
- The member can send an email to Aetna Better Health at **pamedicaidappeals&grievance@aetna.com**
- The member can write down their Grievance and send it to Aetna Better Health of Pennsylvania by mail or fax to Aetna Better Health, Attn: Complaints, Grievances & Appeals, PO Box 81139, 5801 Postal Rd, Cleveland, OH 44181, fax: **860-754-1757**

We will send the member's request to the Department of Health within 24 hours after receiving it.

The member must ask for a Fair Hearing within 120 days from the date on the notice telling them about the expedited grievance decision.

What kind of help can the member have with the complaint and grievance processes?
If the member needs help filing their complaint or grievance, an Aetna staff member will help them. This person can also represent the member during the complaint or grievance process. The member does not have to pay for the help of a staff member. This staff member will not have been involved in any decision about the member's complaint or grievance.

The member may also have a family member, friend, lawyer or other person help them file your complaint or grievance. This person can also help the member if the member decides they want to appear at the complaint or grievance review.

At any time during the complaint or grievance process, the member can have someone they know represent them or act for them. If the member decides to have someone represent or act for them, tell us, in writing, the name of that person and how we can reach him or her.

The member or the person they choose to represent them may ask us to see any information we have about the issue the member filed their complaint or grievance about at no cost to the member.

The member may call our toll-free telephone number at **1-866-638-1232 (PA Relay: 711)** if they need help or have questions about complaints and grievances, they can contact their local legal aid office at **1-800-322-7572** or call the Pennsylvania Health Law Project at **1-800-274-3258**.

Persons whose primary language is not English
Aetna Better Health of Pennsylvania will provide the language services if requested by a member at no cost to the member.

Persons with disabilities

Aetna Better Health of Pennsylvania will provide persons with disabilities with the following help in presenting complaints or grievances at no cost, if needed. This help includes:

- Providing sign language interpreters
- Providing information submitted by Aetna Better Health at the complaint or grievance review in an alternative format; the alternative format version will be given to the member before the review
- Providing someone to help copy and present information

Filing timeframes (complaints and grievances)

FILING COMPLAINTS: first level timeframe
60 calendar days from the date of the incident or the date the member receives written notice of the decision.
Filing complaints: second level timeframe
45 calendar days from the date the member receives written notice of our first level complaint decision.
Expedited review timeframe
Within 48 hours of when we receive the provider's letter or 72 hours from the time the member files a request for an early decision. You need to submit a letter explaining why waiting the standard 30 days would harm the member's health.
External expedited review timeframe
Two business days from the date the member receives the expedited complaint decision notice.
External review of second level complaint
15 calendar days from the date the member receives the written notice of our complaint decision.

FILING GRIEVANCES: first level timeframe
60 calendar days from the date the member receives the written notice to file a grievance.
Expedited review timeframe
Within 48 hours of when we receive the provider's letter or 72 hours from the time the member files a request for an early decision. You need to submit a letter explaining why waiting the standard 30 days would harm the member's health.
External expedited review timeframe
Two business days from the date the member receives the expedited grievance decision notice.
External review of grievance timeframe
15 calendar days from the date the member receives the written notice of the grievance decision.

Resolution timeframes

Aetna Better Health resolves each complaint or grievance as expeditiously as the member's health requires, but no later than the timeframe identified by the Department of Human Services.

Complaints decision: first level complaint timeframe
30 calendar days from receipt of the complaint, which may be extended 14 calendar days at the request of the member.
Complaints decision: second level complaint timeframe
45 calendar days from receipt of the member's second level complaint.
Expedited review timeframe
Within 48 hours of receiving the provider certification or 72 hours of receiving the member's request for an expedited review, whichever is shorter for an expedited complaint.
Expedited external review timeframe
Within 2 business days from receipt of the expedited decision.
External review timeframe
Within 60 days of the date that the member asked for an external review.

Grievances decision – timeframes

Grievances decision: first level grievance timeframe
30 calendar days from receipt of the grievance, which may be extended 14 calendar days at the request of the member.
Expedited review timeframe
Within either 48 hours of receiving the provider certification or 72 hours of receiving the member's request for an expedited review, whichever is shorter for an expedited grievance.
Expedited external review timeframe
Within 2 business days from receipt of the expedited decision.
External review timeframe
Within 60 days of the date that the member asked for an external review.

Department of Human Services Fair Hearings

In some cases, the member can ask the Department of Human Services to hold a hearing because they are unhappy about or do not agree with something Aetna Better Health of Pennsylvania did or did not do. These hearings are called "Fair Hearings ." The member can ask for a Fair Hearing after Aetna Better Health of Pennsylvania decides their First Level Complaint or decides their Grievance.

What can the member request a Fair Hearing about, and by when does the member have to ask for a Fair Hearing?

The member's request for a Fair Hearing must be postmarked within 120 days from the date on the notice telling the member Aetna Better Health's decision on their First Level Complaint or Grievance about the following:

- The denial of a service or item the member wants because it is not a covered service or item
- The denial of payment to a provider for a service or item the member received and the provider can bill the member for the service or item
- Aetna Better Health's failure to decide a First Level Complaint or Grievance the member told Aetna about within 30 days from when Aetna got the complaint or grievance
- The denial of the member's request to disagree our decision that they have to pay their provider
- The denial of a service or item, decrease of a service or item or approval of a service or item different from the service or item the member requested because it was not medically necessary
- They're not getting a service or item within the time by which they should have received a service or item

The member can also request a Fair Hearing within 120 days from the date on the notice telling them that Aetna Better Health failed to decide a First Level Complaint or Grievance they told Aetna about within 30 days from when Aetna got their Complaint or Grievance.

How does the member ask for a Fair Hearing?

The member's request for a Fair Hearing must be in writing. The member can either fill out and sign the Fair Hearing Request Form included in the Complaint or the Grievance decision notice or write and sign a letter.

If the member writes a letter, it needs to include the following information:

- The member's name and date of birth
- A telephone number where the member can be reached during the day
- Whether the member wants to have the Fair Hearing in person or by telephone
- The reason(s) the member is asking for a Fair Hearing
- A copy of any letter the member received about the issue they are asking for a Fair Hearing

The member must send their request for a Fair Hearing to the following address:

Department of Human Services
Office of Medical Assistance Programs HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

What happens after the member asks for a Fair Hearing?

The member will get a letter from the Department of Human Services' Bureau of Hearings and Appeals telling them where the hearing will be held and the date and time for the hearing . The member will receive this letter at least 10 days before the date of the hearing.

The member may come to where the Fair Hearing will be held or be included by phone. A family member, friend, lawyer or other person may help the member during the Fair Hearing. The member MUST participate in the Fair Hearing.

Aetna Better Health will also go to the Fair Hearing to explain why we made the decision or explain what happened.

The member may ask us to give them any records, reports and other information about the issue they requested their Fair Hearing about at no cost to the member.

When will the Fair Hearing be decided?

The Fair Hearing will be decided within 90 days from when the member filed their Complaint or Grievance with Aetna Better Health of Pennsylvania, not including the number of days between the date on the written notice of the Aetna's First Level Complaint decision or Grievance decision and the date the member asked for a Fair Hearing.

If the member requested a Fair Hearing because Aetna Better Health did not tell the member its decision about a Complaint or Grievance they told Aetna about within 30 days from when Aetna got their Complaint or Grievance, the member's Fair Hearing will be decided within 90 days from when they filed their Complaint or Grievance with Aetna, not including the number of days between the date on the notice telling the member that Aetna failed to timely decide their Complaint or Grievance and the date they asked for a Fair Hearing.

The Department of Human Services will send the member the decision in writing and tell the member what to do if they do not like the decision.

If the member's Fair Hearing is not decided within 90 days from the date the Department of Human Services receives their request, the member may be able to get their services until your Fair Hearing is decided. The member can call the Department of Human Services at **1-800-798-2339** to ask for their services.

Continuation of services

If the member has been getting the services or items that are being reduced, changed or denied and they ask for a Fair Hearing and their request is postmarked or hand-delivered within 10 days of the date on the notice telling them about Aetna Better Health's First Level Complaint or Grievance decision, the services or items will continue until a decision is made.

Expedited Fair Hearing

What can the member do if their health is at immediate risk?

If you believe that waiting the usual timeframe for deciding a Fair Hearing could harm the member's health, the member may ask that the Fair Hearing take place more quickly. This is called an expedited Fair Hearing. The member can ask for an early decision by calling the Department at **1-800-798-2339** or by faxing a letter or the Fair Hearing Request Form to **717-772-6328**. You must fax a signed letter to **717-772-6328** explaining why taking the usual amount of time to decide the member's Fair Hearing could harm their health. If you do not send a letter, you must testify at the Fair Hearing to explain why taking the usual amount of time to decide the member's Fair Hearing could harm their health.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell the member its decision within three business days after they asked for a Fair Hearing.

If you do not send a written statement and do not testify at the Fair Hearing, the Fair Hearing decision will not be expedited. Another hearing will be scheduled and the Fair Hearing will be decided using the usual timeframe for deciding a Fair Hearing.

Members can call Aetna Better Health at **1-866-638-1232 (PA Relay: 711)** if they need help or have questions about Fair Hearings, or they can contact their local legal aid office at **1-800-322-7572** or call the Pennsylvania Health Law Project at **1-800-274-3258**.

Chapter 15

Detecting fraud and abuse

The vast majority of Medical Assistance (MA) providers and members deliver and receive care within the boundaries of applicable regulations. Unfortunately, a small number of MA members and providers may engage in practices that are fraudulent or abuse the MA program. The DHS is committed to eliminating all forms of fraud and abuse within the MA program.

We employ a variety of methods to detect potential fraud and abuse, including monitoring claim edits, prior authorization, utilization and concurrent review, Quality Management audits and provider profiling.

We have also developed algorithms to detect potential claims upcoding, with follow-up procedures for chart audits as appropriate. Also, our business software applications use historical claims information to detect and correct questionable billing practices. Claims that reach an adjudicated status of "pay" will receive a control edit, which includes, but is not limited to:

- Verification of member eligibility
- Verification of covered services
- Determining whether services are within the scope of a provider's specialty
- Valid prior authorization
- Submission of required documentation
- Excessive or unusual services based on the member's age or gender
- Duplication of services
- Invalid procedure codes
- Duplicate claims

Federal False Claims Act (FCA)

We support efforts to detect, prevent and report fraud and abuse within the Medicaid system. These efforts are consistent with our mission to provide care to our members while exercising sound fiscal responsibility. Management of limited resources is a key part of this responsibility. Examples of actions that we will report to the state's investigative agencies include:

- Consistently demonstrating a pattern of submitting falsified encounters or service reports
- Consistently demonstrating a pattern of overstated reports or up coded levels of service
- Altering, falsifying or destroying clinical record documentation
- Making false statements relating to credentials
- Misrepresenting medical information to justify enrollee referrals
- Failing to render medically necessary covered services that providers are obligated to provide according to their contract
- Charging enrollees for covered services

Investigating fraud and abuse

If we receive reports of potential fraud and abuse, our staff will document the information, issue a tracking number and report it to the Department of Human Services and other appropriate investigative and law enforcement agencies regardless of whether or not they are resolved internally.

Aetna's Special Investigations Unit (SIU) is responsible for the health care fraud and abuse program. With a total staff of approximately 100 individuals, the SIU department has Medicaid-dedicated staff that support all Aetna Better Health plans, including investigators, analysts and a dedicated technology team. This staff has backgrounds in pharmacy, coding, fraud examination, Medicaid compliance, nursing, law and law enforcement. This team also has dedicated and in-state investigators as well as a dedicated senior medical director who reviews and consults on fraud, waste and abuse issues. To achieve the integrity objectives of the program, SIU has developed state-of-the-art systems capability to monitor our huge volume of claims data across all health product lines. We use business intelligence software to identify providers whose billing, treatment or patient demographic profiles differ significantly from those of their peers. Our SIU's internal analytics staff runs case- and scheme-specific reports using Structured Query Language, Statistical Analysis System software and Crystal reporting technology to support current investigations and identify new cases. The SIU performs an annual review of the plan to identify high-dollar specialties, providers and procedures codes. This can suggest to our SIU investigators which specialties to review for outlier behavior.

If we identify a case of suspected fraud, SIU's information technology and investigative professionals collaborate closely with external investigators to conduct in-depth analyses of case-related data.

Reporting fraud and abuse

Special Investigative Unit

Aetna's SIU has a national toll-free Fraud Hotline **1-800-338-6361** for members and providers who may have questions, seek information or want to report potential fraud-related problems. The SIU staffs the hotline 24/7/365 and callers can remain anonymous. The hotline has proven to be an effective service. We encourage HealthChoices members, providers and contractors to use it.

Pennsylvania MA Provider Self-Audit Protocol

Network providers may voluntarily disclose overpayments or improper payments of MA funds through the Department's Provider Self Audit Protocol. The protocol is available on the Department of Human Services' website at **www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/default.aspx**; click on the Fraud and Abuse link.

Our Fraud and Abuse Hotline
We have a toll-free Compliance (Fraud and Abuse) Hotline **1-800-333-0119** for membersand providers who may have questions, seek information or want to report potential fraud-related problems.

DHS Provider Compliance Hotline
Providers and members can also report suspected fraud and abuse directly to the DHS Provider Compliance Hotline at **1-866-DHS-TIPS (1-866-379-8477)**. Providers can also make a report online at **https://expressforms.pa.gov/apps/pa/DHS/MA-Provider-Compliance-Hotline** and filling out the MA Provider Compliance Hotline Response Form or send communications to: Department of Human Services Office of Administration,
P.O. Box 2675, Harrisburg, PA 17105-2675.

Reported problems will be referred to the Office of Medical Assistance Program's Bureau of Program Integrity for investigation, analysis and determination of the appropriate courseof action. Aetna Better Health and the DHS maintain strict confidentiality concerning the providers and members who report suspected fraud and abuse.

Fraud and abuse examples
Examples of health care provider fraud and abuse are:

- Billing or charging members for services that we cover (other than co-pays)
- Offering members gifts (other than health plan programs approved by DHS) or money to receive treatment or services
- Offering members free services, equipment or supplies in exchange for use of a member's Aetna Better Health member ID number
- Providing members with treatment or services that they do not need
- Physical, mental or sexual abuse by medical staff

Examples of member fraud and abuse are:

- Selling or lending identification cards to other people
- Living outside Pennsylvania
- Abusing benefits by seeking drugs or services that are not medically necessary

Chapter 16

Forms

We produce a number of forms for providers to expedite and standardize administrative functions. Provider orientation includes a review of these forms. If you have any questionsor would like help completing forms, contact your Provider Relations Representative at **1-866-638-1232**.

For sample forms visit **AetnaBetterHealth.com/PA/providers/forms**.

Links

Care Management Referral Form:
AetnaBetterHealth.com/PA/assets/pdf/provider/provider-forms/Blank-CM-referral-form-2018.pdf

ePocrates (registration required):
online.epocrates.com/rxmain.jsp

Fee schedule:
www.humanservices.state.pa.us/outpatientfeeschedule

Immunization schedules:
www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

Pharmacy formulary:
AetnaBetterHealth.com/PA/providers/pharmacy

Prior authorization form:
AetnaBetterHealth.com/PA/assets/pdf/provider/PriorAuthForm-NDCCode_PA.pdf

Prior authorization checklist:
AetnaBetterHealth.com/PA/assets/pdf/provider/notices/Prior-Authorization-Checklist_FINAL-UA.pdf

Provider appeals:
AetnaBetterHealth.com/PA/assets/pdf/provider/provider-forms/ProviderAppealFormABH-PANewAddress0617.pdf

Provider education resources:
AetnaBetterHealth.com/PA/providers/education

Provider portal:
AetnaBetterHealth.com/PA/providers/portal

Quality improvement resources:
AetnaBetterHealth.com/PA/providers/quality-improvement-resources

Chapter 17

Glossary of key terms

Abuse
Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the MA program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or agreement obligations (including the RFP, agreement, and the requirements of state or federal regulations) for health care in a managed care setting.

Access card
An identification card issued by the department to each MA recipient. This card must be used by MA-enrolled health care providers to access the department's EVS and verify a HealthChoices member's MA eligibility and specific covered benefits.

Behavioral health managed care organization (BH-MCO)
An entity operated by county government or licensed by the commonwealth as a risk-bearing health maintenance organization (HMO) or preferred provider organization (PPO), which manages the purchase and provision of behavioral health services under an agreement with the Department of Human Services.

Business day
A business day includes Monday through Friday except for those days recognized as federal holidays and/or Pennsylvania state holidays.

Capitation
A payment the department makes periodically to a PH-MCO on behalf of each member enrolled under the agreement and based on the actuarially sound rate for the provision of services under the state plan. The Department of Human Services makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

Care Management
Care Management programs apply systems, science, incentives and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to more effectively manage medical/social/mental health conditions. The goal of Care Management is to achieve an optimal level of wellness and improve coordination of care while providing cost-effective, non-duplicative services.

Adapted from: R. Mechanic. *Will Care Management improve the value of U.S. health care?* Background paper for the 11th annual Princeton conference.

Case Management Services
Services which will assist individuals in gaining access to necessary medical, social, educational and other services.

Centers for Medicare and Medicaid Services
The federal agency within the Department of Health and Human Services responsible for oversight of MA programs.

Certified registered nurse practitioner (CRNP)
A professional nurse licensed in the Commonwealth of Pennsylvania who is certified by the State Board of Nursing in a particular clinical specialty area and who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in Pennsylvania.

Children in Substitute Care
Children who have been adjudicated dependent or delinquent and who are in the legal custody of a public agency or under the jurisdiction of the juvenile court and are living outside their homes, in any of the following settings: shelter homes, foster homes, group homes, supervised independent living, and RTFs for Children.

Claim
A bill from a provider of a medical service or product that is assigned a unique identifier (i.e., Claim reference number). A Claim does not include an Encounter form for which no paymentis made or only a nominal payment is made.

Clean claim
a claim that can be processed without obtaining additional information from the provider of the service or from a third party. A clean claim includes a claim with errors originating in the PH-MCO's claims system . Claims under investigation for fraud or abuse or under review to determine if they are medically necessary are not clean claims.

Client Information System (CIS)
The department's database of recipients. The data base contains demographic and eligibility information for all recipients.

Clinical Sentinel Hotline
Resource operated by OMAP. Staff is available to assist MA members with obtaining timely responses to requests for medically necessary care and services. Staff does not approve or deny services . However, they assist with problem solving for MA members who call the hotline.

Community provider
Private and public organizations that are not part of Aetna Better Health's provider network, with which Aetna Better Health coordinates out-of-plan services for their members.

Complaint
A dispute or objection regarding a participating health care provider or the coverage, operations or management policies of Aetna Better Health, which has not been resolved by Aetna Better Health and has been filed with Aetna Better Health or with the Department of Health or the Pennsylvania Insurance Department of the Commonwealth, including but not limited to:

- A denial because the requested service/item is not a covered benefit
- The failure to meet the required timeframes for providing a service/item
- The failure of Aetna Better Health to decide a complaint or grievance within the specified timeframes
- A denial of payment by Aetna Better Health after a service has been delivered because the service/item was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program
- A denial of payment by Aetna Better Health after a service has been delivered because the service/item provided is not a covered service/item for the member or
- A denial of a member's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other member financial liabilities

The term "complaint" does not include a grievance.

Complete medical history
A chronological medical record that includes, but is not limited to, major medical complaints, present medical history, past medical history, family history and social history.

Concurrent review
A review conducted by Aetna Better Health during a course of treatment to determine whether the amount, duration and scope of the prescribed services continue to be medically necessary or whether a different service or lesser level of service is medically necessary.

CORE
CORE stands for consolidated outreach and risk evaluation . CORE is Aetna Medicaid's proprietary methodology for identifying high-risk members for outreach and evaluation. CORE is based on three risk metrics:

- Predictive pathways risk score – ranking by score the highest to lowest "high-risk" members
- Emergency department risk score – risk of an emergency department visit in the next 12 months
- Inpatient admission risk score – risks of an inpatient department admit in the next 12 months

County Assistance Office (CAO)
The county offices of the department that administer all benefit programs, including MA, on the local level. Department staff in these offices performs necessary functions such as determining and maintaining MA member eligibility.

Covered service
A benefit to which a MA member is entitled under the MA program of the Commonwealth of Pennsylvania.

Cultural competency
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.

Denial of services
Any determination made by Aetna Better Health in response to a request for approval which:
- Disapproves the request completely
- Approves provision of the requested service(s), but for a lesser amount, scope, or duration than requested
- Disapproves provision of the requested service(s), but approves provision of an alternative service(s)
- Reduces, suspends or terminates a previously authorized service

An approval of a requested service which includes a requirement for a concurrent review by Aetna Better Health during the authorized period does not constitute a denial of service.

Department
The Department of Human Services (DHS) of the Commonwealth of Pennsylvania.

Developmental disability
A severe, chronic disability of an individual that is:
- Attributable to a mental or physical impairment or combination of mental or physical impairments
- Manifested before the individual reaches age 22
- Likely to continue indefinitely
- Manifested in substantial functional limitations in three or more of the following areas of life activity: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency
- Reflective of the individual's need for special, interdisciplinary or generic services, supports or other assistance that is of lifelong or extended duration, except in the cases of infants, toddlers or preschool children who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided

Disease Management
An integrated treatment approach that includes the collaboration and coordination of patient care delivery systems. The approach focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education and outpatient care. Coordination also includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition.

DHS Fair Hearing
A hearing conducted by the Department of Human Services, Bureau of Hearings and Appeals.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT/Bright Futures)
Items and services that must be made available to persons under the age of 21 upon a determination of medical necessity and required by federal law at 42 U.S.C. §1396D(r).

Eligibility Verification System (EVS)
An automated system available to MA providers and other specified organizations for automated verification of MA members' current and past (up to 365 days) MA eligibility, Aetna Better Health enrollment, PCP assignment, third-party resources and scope of benefits.

Emergency medical condition
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part.

Emergency services
Covered inpatient and outpatient services that: a) are furnished by a provider that is qualified to furnish such service under Title XIX of the social security act and b) are needed to evaluate or stabilize an emergency medical condition.

Enrollment Assistance Program (EAP)
The program that provides enrollment specialists to assist MA members in selecting a PH-MCO and primary care practitioner (PCP) and in obtaining information regarding HealthChoices physical and behavioral health services and service providers.

Enrollment specialist (ES)
The individual responsible to assist MA members with selecting a PH-MCO and PCP as well as providing information regarding physical and behavioral health services and service providers under the HealthChoices program.

Expanded services
Any medically necessary service covered under Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., but not included in the state's Medicaid plan, which is provided to members.

Experimental treatment
A course of treatment, procedure, device or other medical intervention that is not yet recognized by the professional medical community as an effective, safe and proven treatment for the condition for which it is being used.

External Quality Review (EQR)
A requirement under Section 1902(a)(30)(c) of Title XIX of the Social Security Act, 42 U.S.C.1396(A)(30)(c) for states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with managed careorganizations, including the evaluation of quality outcomes, timeliness and access to services.

Federally Qualified Health Center (FQHC)
An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C. 1396D (l) or is receiving funding from such a grant under a contract with the member of such a grant and meets the requirements to receive a grant under the above-mentioned sections of the act.

Fee-For-Service (FFS)
Payment by the department of human services to providers on a per-service basis for health care services provided to MA members.

Fraud
Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself or some other person in a managed care setting. The fraud can be committed by many entities, including a PH-MCO, a subcontractor, a provider, a state employee or a member, among others.

Grievance
A request to have Aetna Better Health or a utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. A grievance may be filed regarding an Aetna Better Health decision to:

1) deny, in whole or in part, payment for a service/item
2) deny or issue a limited authorization of a requested service/item, including the type or level of service/item
3) reduce, suspend or terminate a previously authorized service/item
4) deny the requested service/item but approve an alternative service/item
5) deny a request for a benefit limit exception (BLE). The term does not include a complaint

Health care provider
A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of the commonwealth or state(s) in which the entity or person provides services, including: a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA means the administrative simplification, privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) . Administrative simplification is found in parts 160 and 164 of 45 C.F.R, and the HIPAA Privacy Rule (Privacy Rule) is in 45 C .F .R . Parts 160 and 164, as amended and the HIPAA Security Rule (Security Rule) is in 45 C.F.R. Parts 160, 162 and 164, as amended.

HealthChoices program
The name of Pennsylvania's 1915 (b) waiver program to provide mandatory managed health care to members.

Home- and community-based waiver program
Necessary and cost-effective services not otherwise furnished under the state's Medicaid plan or services already furnished under the state's Medicaid plan but in expanded amount, duration or scope which are furnished to an individual in his/her home or community in order to prevent institutionalization. Such services must be authorized under the provisions of 42 U.S.C. 1396N.

Medical Assistance Transportation Program (MATP)
A non-emergency medical transportation service provided to eligible persons who need to make trips to/from a MA reimbursable service for the purpose of receiving treatment, medical evaluation or purchasing prescription drugs or medical equipment.

Medically necessary
A service or benefit is medically necessary if it is compensable under the MA program and if it meets any one of the following standards:

- The service or benefit will or is reasonably expected to, prevent the onset of an illness, condition or disability
- The service or benefit will or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability
- The service or benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age

Determination of medically necessary covered care and services, whether made on a prior authorization, concurrent review, retrospective review or exception basis, must be documented in writing. The determination is based on medical information provided by the member, the member's family/caretaker and the primary care practitioner, as well as any other providers, programs, agencies that have evaluated the member. All such determinations must be made by qualified and trained health care providers. A health care provider who makes such determinations of medical necessity is not considered to be providing a billable health care service under the terms of the HealthChoices program agreement.

Member
An MA member who is enrolled with Aetna Better Health under the HealthChoices program and for whom Aetna Better Health has agreed to arrange the provision of physical health services under the provisions of the HealthChoices program.

Network provider
A medical assistance enrolled health care provider who has a written Provider Agreement with and is credentialed by Aetna Better Health and who participates in Aetna Better Health's provider network to serve HealthChoices members.

Non-participating provider
A provider, whether a person, firm, corporation or other entity, either not enrolled in the Pennsylvania MA program or not participating in Aetna Better Health's network providing medical services or supplies to Aetna Better Health's members.

Other resources
With regard to third-party liability (TPL), "other resources" include, but are not limited to, recoveries from personal injury claims, liability insurance, first-party automobile medical insurance and accident indemnity insurance.

Out-of-area covered services
Medical services provided to MA members under one or more of the following circumstances:

- An emergency medical condition that occurs while outside the HealthChoices zone covered by this agreement
- The health of the member would be endangered if the member returned to this HealthChoices zone covered by this agreement for needed services
- The provider is located outside the HealthChoices zone, but nonetheless regularly provides medical services to members at the request of the Aetna Better Health or
- The needed medical services are not available in the HealthChoices zone

Out-of-network provider
A health care provider who has not been credentialed by and does not have a signed Provider Agreement with Aetna Better Health.

Out-of-plan services
Services which are non-plan, non-capitated and are not the responsibility of Aetna Better Health under the HealthChoices program comprehensive benefit package.

Provider dispute
A written communication to Aetna Better Health, made by a provider, expressing dissatisfaction with an Aetna Better Health decision that directly impacts the provider. This does not include decisions concerning medical necessity.

Quality Management (QM)
An ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care. This methodology is used by professional health personnel that review the degree to which services provided and results achieved conform to desired medical practices and standards. Activities are then designed to improve and maintain quality service and care. This is performed through a formal program with involvement of multiple organizational components and committees.

Retrospective review
A review conducted by Aetna Better Health to determine whether services were delivered as prescribed and consistent with our payment policies and procedures.

School-based health services
An array of medically necessary health services performed by licensed professionals that may include, but are not limited to, immunization, well-child care and screening examinations in a school-based setting.

Special needs
The circumstances for which a member will be classified as having a special need will be based on a non-categorical or generic perspective that identifies key attributes of physical, developmental, emotional or behavioral conditions, as determined by DHS.

Special Needs Unit (SNU)
A special dedicated unit within Aetna Better Health's and the employee assistance program contractor's organizational structure established to deal with issues related to members with special needs.

Targeted Care Management (TCM) program
A Care Management program for members who are diagnosed with AIDS or symptomatic HIV.

Third-party resource (TPR)
Any individual, entity or program that is liable to pay all or part of the medical cost of injury, disease or disability of a member . Examples of third-party resources include government insurance programs such as Medicare or Champus (Civilian Health and Medical Program of the Uniformed Services); private health insurance companies or carriers, liability or casualty insurance and court-ordered medical support.

Urgent medical condition
Any illness, injury or severe condition which under reasonable standards of medical practice, would be diagnosed and treated within a 24-hour period and if left untreated, could rapidly become a crisis or emergency medical condition. The term also includes situations where a person's discharge from a hospital will be delayed until services are approved or a person's ability to avoid hospitalization depends upon prompt approval of services.

Utilization Management (UM)
An objective and systematic process for planning, organizing, directing and coordinating health care resources to provide medically necessary, timely and quality health care services in the most cost-effective manner.

Utilization review criteria
Detailed standards, guidelines, decision algorithms, models or informational tools that describe the clinical factors to be considered relevant to making determinations of medical necessary including, but not limited to, level of care, place of service, scope of service and duration of service.

Any questions? Call Provider Relations
1-866-638-1232

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