Provider Newsletter Summer 2019

Provider Notices

Please find our updated and current clinical and medical policies on Aetna Better Health of Illinois's website. These updates address issues such as prior authorization requirements and changes. Relevant updates are posted in a timely manner for your convenience.

Claim and Configuration Projects

We are excited to announce a new feature to better communicate with you which will include active updates on processing issues and the role you, as the provider, can have in remediating these issues. This new process is accessible on our website under Claim and Configuration Projects.

Included in these reports will be information regarding when issues are identified, the expected timeline for project completion, when the issue is fixed, and when claims will be reprocessed. We hope the increased communication will strengthen our relationship with you and allow us to better resolve the system issues at-hand.

Don't Let Your Network Status Change: Complete your FDR Attestation Today

If you are a participating provider in our Medicare plans and/or our Medicare-Medicaid plans (MMPs), you must meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related (FDR) entities. You also must confirm your compliance with these requirements through an annual attestation.

How to Complete your Attestation

You'll find the resources you need to ensure your compliance on the Medicare Compliance Attestation page of aetna.com. Once on the page, click "See Our Medicare Compliance Program Guide" or "See Our Office Manual" under "Need More Information."
Once you review the information and ensure that you've met the requirements, you're

ready to complete your attestation. Simply click the link on the Medicare Compliance Attestation page that corresponds to ensure your contracting status. A single annual attestation meets all your Aetna, Coventry and/or MMP compliance obligations.

Appointment Availability Standards & Timeframes

Appointments must be scheduled in accordance with the *minimum appointment availability standards*. This is subject to the acuity and severity of the presenting condition and the enrollee's past and current medical history. Aetna's Provider Services Department routinely monitors compliance and seeks Corrective Action Plans (CAP), such as
panel or referral restrictions should providers not comply with the accessibility standard. These standards are set to benefit the patient. Providers are contractually obligated to meet standards determined by Illinois Healthcare and Family Services (HFS) and the National Committee for Quality Assurance (NCQA) to ensure timely access to care, accounting for the urgency of and need for the respective services.

The table below indicates the standard appointment wait times for Primary Care Providers (PCP), Behavioral Health Clinics, and Specialists, such as Obstetrics and Gynecologist (OB/GYNs).

Provider Type	Emergency Appointment Timeframe	Urgent Appointment Timeframe	Preventive & Routine Appointment Timeframe	Appointment Wait Time (Office Setting)
Primary Care	Immediately upon member's request	Within 48-hours of member's request	Within 6-weeks of member's request; Not applicable for: routine physical examinations, regularly scheduled visits to monitor chronic medical conditions if the schedule calls for visits less frequently than once every six calendar days	No more than 60 minutes
Specialty Care				
Primary Care	Same Day	Within 2 calendar days	Within 3 weeks	No more than 60 minutes
Specialty Referral	Immediate	Within 2 calendar days	Within 3 weeks	No more than 60 minutes

OB/GYN	Immediate	Within 72 hours	Within 2 weeks Prenatal Care: First Trimester: within 14 calendar days of request Second Trimester: within 7 calendar days of request Third Trimester: within 3 business days of request	No more than 60 minutes
Oncologist and other High Impact Specialist	Immediate	Within 2 days	Within 3 weeks	No more than 60 minutes
Physical Therapy	Within 24 hours	Within 72 hours	Within 2 weeks	No more than 60 minutes
Occupational Therapy	Within 24 hours	Within 72 hours	Within 2 weeks	No more than 60 minutes
Sports Medicine	Within 24 hours	Within 72 hours	Within 2 weeks	No more than 60 minutes
Behavioral Health	**Potentially suicidal individual:** immediate treatment **Non-life-threatening urgent*:** within 6 hours	Urgent- No Immediate danger**: Within 48 hours	Initial visit within 10 business days of official request	No more than 60 minutes

*No immediate danger to self or others and/or if not addressed within 6 hours may escalate to: extreme anxiety, parent child issues, passive suicidal ideation, excess drug or alcohol usage

**No immediate danger to self or others and/or if not addressed within 48 hours may escalate to: follow-up to a crisis stabilization, escalating depression, escalating anxiety, escalating drug/alcohol usage, escalating behavioral issues in children

Behavioral health providers are contractually required to offer:

Provider Type	Follow-up BH Medication Mgt.	Follow-up BH Therapy	Next Follow-up BH Therapy
Behavioral Health	Within 3 months of first appointment	Within 10 business days of first appointment	Within 30 business days of first appointment

Complex Case Management Referral Options

Empowerment through case management

Aetna Better Health Premier Plan offers an evidence-based case management program to help our members improve their health and access the services they need. Case managers typically are nurses or social workers. These professionals create comprehensive care plans that help members meet specific health goals.

All members are assigned their own case manager. The amount of care management a member receives is based upon an individual member's needs. Some of the reasons you may want to ask the health plan to have a case manager contact the member are:

- Does the member frequently use the emergency room instead of visiting your office for ongoing issues?
- Has the member recently had multiple hospitalizations?
- Is the member having difficulty obtaining medical benefits ordered by providers?
- Has the member been diagnosed with Congestive Heart Failure (CHF) diabetes, asthma, or Chronic Obstructive Pulmonary Disorder (COPD), yet does not comply with the recommended treatment regimen?
- Does the member need help to apply for a state-based long-term care program?
- Does the member have HIV?
- Is the member pregnant with high-risk conditions?
- Is the member pregnant and over 35 years of age?
- Has the member received a referral to a specialist, but is unsure of the next steps?
- Does the member need information on available community services and resources not covered by Medicaid (e.g. energy assistance, SNAP, housing assistance)?

What happens to your referral?

After you make a referral, the member's case manager contacts the member. The case manager might also contact the member's caregivers or others as needed.

What will a case manager do?

To help the member learn how to manage their illness and meet their health and other needs, a case manager contacts the member to schedule a time to complete an assessment. The case manager asks the member questions about his or her health and the resources currently being used. Answers to these questions help the care manager determine what kind of assistance the member needs most.

Next, the member and the case manager work together to develop a care plan. The case manager also educates the member on how to obtain what they need. The case manager also may work with the member's health care providers to coordinate these needs. The amount of case management and frequency of contact with the member and others will vary based upon the individual needs of the member.

To make referrals for case management consideration, please call Provider Services at 1-866-600- 2139. A case manager will review and respond to your request within 3-5 business days.

Clinical Criteria for Utilization Management Decisions

How to Request Criteria
Aetna Better Health Premier Plan's medical necessity decisions for requested medical and behavioral services are based upon CMS National Coverage and Local Coverage Determinations, and nationally recognized evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system.

Aetna uses the following medical review criteria for physical and behavioral health medical necessity decisions which are consulted in the following order:

- Criteria required by applicable state or federal regulatory agency
  - National Coverage Determination (NCD)
  - Local Coverage Determination (LCD)
- Pharmacy clinical guidelines
- MCG guidelines (Physical and Behavioral Health)
- Aetna Medicaid Pharmacy Guidelines
- Level of Care Utilization System (LOCUS)
- American Society of Addiction Medicine (ASAM)
- Aetna Clinical Policy Bulletins (CPBs)
- Aetna Clinical Policy Council Review

The criteria and guidelines are disseminated to all affected practitioners, and/or providers, upon request.

To request criteria, call Provider Services at 1-866-600-2139 or visit our website

Affirmative Statement

Making sure members get the right care
Our utilization management (UM) program ensures members receive the right care in the right setting when they need it. UM staff can help you and our members make decisions about their health care. Our UM program helps make sure members receive the right services at the right place. When we make decisions, it's important to remember the following:

- We make UM decisions by looking at members' benefits and choosing the most appropriate care and service. Members also must have active coverage.
- We don't reward providers or other people for denying coverage or care.
- Our employees do not get any incentives to reduce the services members receive.

You can speak to a person to ask questions about UM by calling Utilization Management toll-free at 1-866-600-2139, 24 hours a day, 7 days a week. Language translation for members is provided for free by calling 1-800-385-4104.

Procedures for Pharmaceutical Management

Pharmacy Benefits

Visit aetnabetterhealth.com/Illinois for the updated pharmacy formulary and latest member handbook. For a printed copy of anything on our website, call Member Services toll-free at 1- 866- 600-2139.

Pharmacy Electronic Prior Authorization

Pharmacy will offer Electronic Prior Authorization (ePA) starting September 2, 2019.

Aetna Better Health® of Illinois is partnering with CoverMyMeds® and SureScripts to provide you a new way to request a pharmacy prior authorization through the implementation of Electronic Prior Authorization (ePA) program.

Benefits of Electronic Prior Authorization (ePA):

- Time saving
  - Decreases paperwork, phone calls, and faxes for requests for prior authorization
- Quicker determinations
  - Reduces average wait times and faster resolution
  - Find out if a prior authorization is required for the drug right away
- Accommodating and secure
  - HIPAA compliant via electronically submitted requests

Let us help get you started! Create a free account today!

Getting started is easy. Choose ways to enroll:

- Visit the CoverMyMeds® website
- Call CoverMyMeds® toll-free at **866-452-5017**
- Visit the SureScripts website
- Call SureScripts toll-free at **866-797-3239**

Statement of Member Rights and Responsibilities

Member Rights and Responsibilities

As a practitioner who ensures high quality care for Aetna Better Health Premier Plan members, you should be aware of the members' rights and responsibilities. Some of the rights we provide to our members are as follows:

- A right to receive information about Aetna, our services, our practitioners and providers, and member rights and responsibilities
- A right to be treated with respect and recognition of the member's dignity and right to privacy
- A right to participate with practitioners in making decisions about their health care
- A right to a candid discussion of appropriate or medically necessary treatment options for a member's condition, regardless of cost or benefit coverage
- A right to voice complaints or appeals about Aetna or the care we provide
- A right to make recommendations regarding Aetna's member rights and responsibilities policy

In addition, our members have the following responsibilities:

- A responsibility to supply information (to the extent possible) that Aetna and our practitioners and providers need in order to provide care
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

For a complete list of member rights and responsibilities visit our website at aetnabetterhealth.com/Illinois to see our Member Handbook.

Member Incentives

Aetna Better Health is asking for your help. Our members can receive incentives for closing specific gaps in care with their providers. Members can receive $25 for each completed service in the program. We are asking for your help in submitting all applicable billing codes for completed services for the members to receive their incentive. All services must be performed in calendar year 2019. Your office will be receiving a comprehensive billing guide with codes for each item listed below from our provider relations team or via fax. All the measures, except for the annual preventive visit, are based on the NCQA's HEDIS specifications. Please feel free to reach out to QMquestions@aetna.comifyou have any questions regarding the below.

Services included in the incentive program are:

- All members who have a preventive wellness visit (your complete Aetna Better Health member roster);
- Women aged 52-74 who appear with a breast cancer screening gap in care on your roster based on HEDIS specifications who completed a screening mammogram in 2019;
- Members with diabetes that appear with a gap in care on your roster based on HEDIS specifications who complete **all three** of the following:
    - Dilated retinal exam
    - HbA1c test
    - Urine microalbumin test or is taking an ACE/ARB
- Members aged 50-74 that appear with a colorecta screening gap in care on your roster based on HEDIS specifications. Compliance includes the following screenings:
    - FOBT/FIT
    - Colonoscopy;
    - Flexible Sigmoidoscopy
    - CT Colonography
    - FIT-DNA
- Members 66 years of age and older who appear with a care for an older adult gap in care on your roster based on HEDIS specifications, and who have **all 4 completed**:
    - Advanced Care Planning discussion or documentation of an executed advanced care plan;
    - Medication review (must submit code for medication review **AND** the presence of a medication list)

- Functional Status Assessment
- Pain Assessment

Telemonitoring

Our remote patient monitoring (Telemonitoring) program affords enrollees the tools they need to monitor and manage their chronic conditions. This program increases an enrollee's autonomy in managing aspects of his or her conditions and provides the opportunity for early intervention should problems arise. Telemonitoring is also used to manage enrollees' chronic health conditions such as:

- Congestive heart failure
- Diabetes
- COPD
- Asthma
- Hypertension
- End stage renal disease

Enrollees' weight changes, blood sugar levels, oxygen levels, blood pressure, pulse and lung function can be assessed remotely to alert our care management team and their providers to changes in enrollees' health.

Early detection reduces enrollee's utilization of emergency services. Even if the patient is assigned a primary care provider, not every enrollee with chronic conditions engages in regular treatment creating *risks* for those individuals. These risks include opportunities to respond timely to clinical changes and delayed treatment resulting in disease progression, thus requiring more acute and costly treatment with less desirable outcomes.

Many times, one of our care managers will offer this benefit to your patients and offer a thorough explanation of its benefits. If your patient agrees to participate, you will receive a fax from our care management department with a provider approval. We ask that you please review and complete this so we can honor the request of your patient to engage in this program.

If you believe your patient would benefit from the Telemonitoring program, please send an email with their name, recipient ID number and date of birth to: **ILTelemonitoringReferrals@aetna.com.** A case manager will reach out to you and the member to continue with education and engagement in the program.

Federally Qualified Health Center Billing Guidelines (FQHC)

Effective immediately, Medicare-Medicaid (MMAI/MMP) Dual Eligible Member Claim submission guidelines:

Encounter reimbursement for services provided to Aetna Better Health members who qualify for both Medicare and Medicaid programs under the Medicare Medicaid Alignment Initiative (MMAI) (Duals program) must be billed according to current CMS guidelines.

All claims for MMAI/MMP Members must be submitted on a UB04 or 837I equivalent. Claims will be processed in accordance with the Prospective Payment System (PPS).

Medicare FQHC and RHC Billing Guidelines

Secondary Medicaid Payment Responsibility in Coordination of Benefits (COB) Situations

Aetna Better Health is committed to ensuring that the claims you submit are processed in a timely and accurate manner. Aetna Better Health serves as a Medicaid managed-care organization (MCO) on behalf of the State of Illinois and arranges for the provision of covered services to its members. When more than one program or payer has payment responsibility for a particular service rendered to a member—for example, when a service is covered under both Medicare and Medicaid—Aetna Better Health follows applicable coordination-of-benefits(COB) principles to determine which program/payer has primary payment responsibility (PPR)for that service. This COB analysis includes a determination of the amount payable by the program/payer having PPR, along with the amounts, if any, payable by programs/payers that have secondary or lower payment responsibility. If a service is covered under *both* Medicaid *and* another program/payer, Medicaid never has PPR.

Under established COB principles, if the amount of the payment made by the program/payer having PPR (*e.g.*, Medicare) *exceeds* the amount that the secondary program/payer (*e.g.*, Medicaid) *would have paid* if it had PPR, then the secondary program/payer has no payment responsibility.

Aetna Better Health has identified an error in the COB method by which it calculated the *Medicaid* amount that is secondarily payable when *Medicare* has PPR for a particular service. Specifically, Aetna Better Health erroneously made certain secondary payments to providers when, under the COB principle described above, the Medicaid amount that was secondarily payable should have been zero.

Please be advised, going forward Aetna Better Health will apply the above-described COB principle strictly and consistently. As a result, the aggregate amount that providers receive from Aetna Better Health for certain services may *decrease* now that the secondarily payable Medicaid amounts on those services will be zeroed out appropriately. Aetna Better Health will apply this COB principle consistently for all claims ***processed*** on or after 01/07/19, regardless of the corresponding date of service. Aetna Better Health may reprocess previously adjudicated claims to recover erroneous secondary overpayments on claims with dates of service in 2018.

If you have any questions and/or concerns, please contact your Network Account Manager.