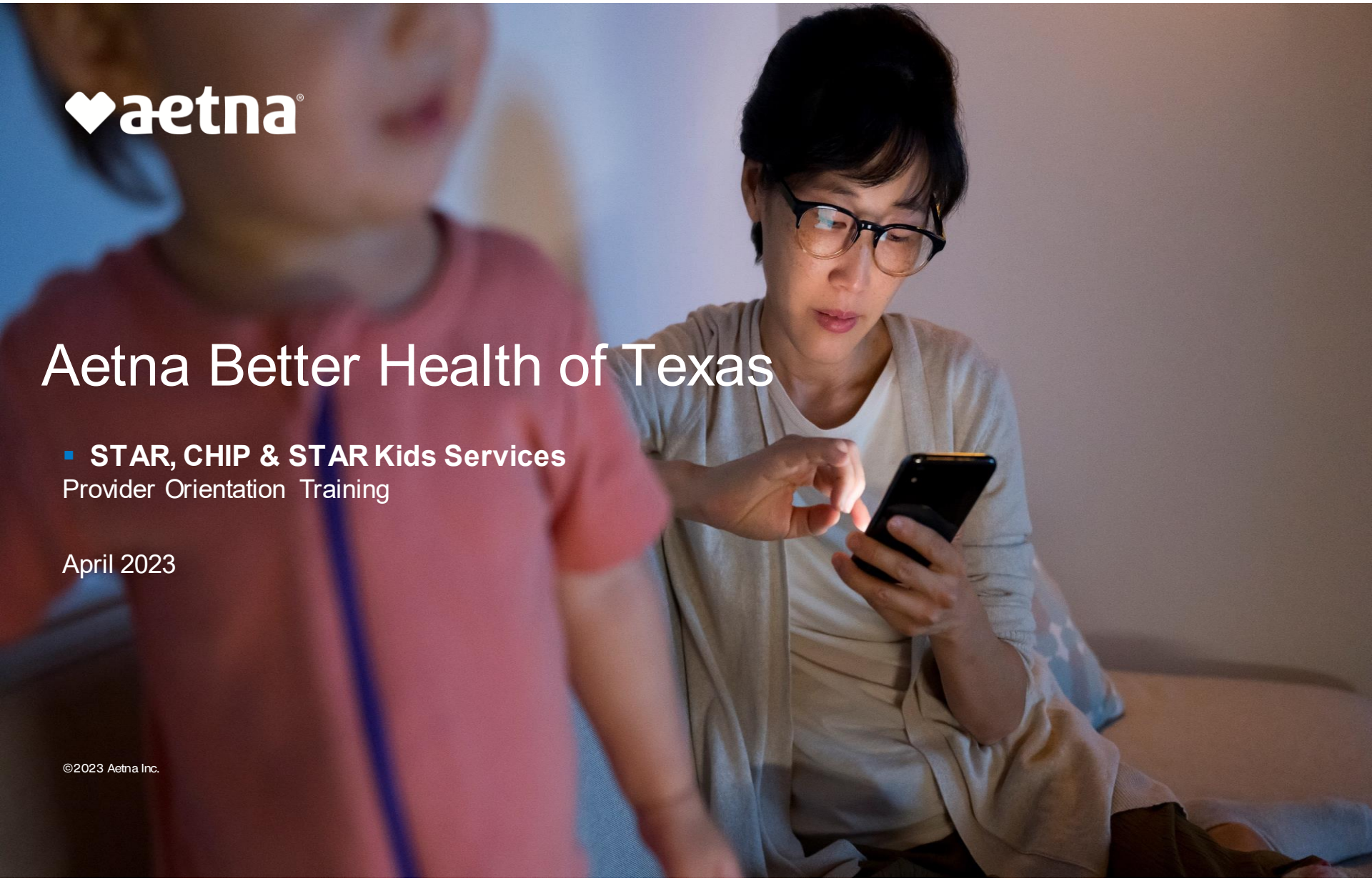


Aetna Better Health of Texas

- **STAR, CHIP & STAR Kids Services**

Provider Orientation Training

April 2023

Objectives

As a result of this training session, you will be able to:

- Describe features and benefits of the Aetna Better Health STAR, CHIP & STAR Kids programs
- Know how to identify Aetna Better Health STAR, CHIP & STAR Kids programs
- Understand the behavioral health, OB/GYN, vision, THSteps services, STAR Kids program features and services
- Know how to find the list of benefits on the Aetna Better Health website
- Locate additional resource information regarding the Aetna Better Health STAR, CHIP & STAR Kids programs
- Understand the differences between Medicaid managed care and traditional Medicaid, CHIP, and CHIP for the unborn child (perinatal).
  - CHIP offers health care benefits related to pregnancy. This is for pregnant women who cannot get Medicaid or other CHIP benefits because: (a) of their immigration status, or (b) they make too much money. There are no fees or co-pays for these benefits.

Overview

- Aetna contracts with the Texas Health and Human Services Commission (HHSC) to administer the Medicaid Managed Care,STAR, CHIP and STAR Kids programs in the Bexar and Tarrant service areas. **Aetna STAR Kids Dallas is administered in the Tarrant service delivery area and beginning September 1, 2020, will begin serving in the Dallas service delivery area.**
- STAR, CHIP and STAR Kids are three separate programs administered by HHSC with different eligibility requirements, benefits and oversight.
- Managed Care includes the member assignment to an in-network PCP to establish a medical home. The PCP coordinates the member's medical care and the health plan works with the PCP, specialists, etc. to ensure appropriate care.
- HHSC determines and provides member eligibility for the STAR, CHIP and STAR Kids programs to Aetna Better Health.
- Aetna Better Health does not sell or market this program directly.
- All enrollment and disenrollment is handled through HHSC's CHIP and Medicaid enrollment broker (Maximus).

Aetna Better Health Medicaid & CHIP Service Areas

Bexar Service Area

- Atascosa
- Bexar
- Comal
- Guadalupe
- Kendall
- Medina
- Wilson
- Bandera

Tarrant Service Area

- Denton
- Hood
- Johnson
- Parker
- Tarrant
- Wise

Aetna Better Health of Texas Counties

STAR Kids coverage areas includes the following counties in the Tarrant Service Area and Dallas Service Area

Tarrant Service Area

- **Denton**
- **Hood**
- **Johnson**
- **Parker**
- **Tarrant**
- **Wise**

Dallas Service Area

(Effective 9/1/2020)

- **Collin**
- **Hunt**
- **Kaufman**
- **Dallas**
- **Navarro**
- **Rockwall**
- **Ellis**

General Program Overview
Aetna Better Health – Medicaid and CHIP

PCP Selection

- Medicaid - required or member is "defaulted" to a PCP upon enrollment into a plan
- CHIP – not required but assigned by health plan
  - CHIP Perinate – not required
- Medicaid and CHIP - Most specialty care is coordinated through PCP. Please note that members do not need a referral from PCPs to get behavioral health care services.
- Medicaid and CHIP - Members access any Aetna Better Health in-network provider
- Medicaid - Members may see any Texas Health Steps (THSteps) provider for THSteps-covered services.

General Program Overview
Aetna Better Health – Medicaid and CHIP

Copayments

- **Medicaid** – does not apply
- **CHIP**
  - Applies based on the federal poverty level (FPL) until cost sharing maximum is met by family.
  - Does not apply for pregnancy-related or preventive services
  - Does not apply for services rendered to American Indian and Alaskan Native Members.
  - Does not apply to ER visits for emergency services related to an emergency diagnosis.
  - Does not apply to value added services.
- **CHIP Perinate Newborn** – copayments do not apply
- **CHIP Perinate** – copayments do not apply

****Please reference to the CHIP Cost Sharing Chart located within the Quick Reference Guide****

General Program Overview (continued) - Medicaid and CHIP

- Lab Services
  - Quest Diagnostics
  - LABCORP
- Use of contracted radiology facilities
- Precertification required for all inpatient hospitalizations and selected outpatient services
- Prescription drugs – coordinated through CVS Caremark
- Direct Access (self-referral):
  - Ob/Gyn
  - Vision services – coordinated through Superior Vision
  - Therapeutic optometry – in-network providers only; excludes surgery
  - Behavioral Health
  - THSteps exams (***Medicaid benefit only***)
  - Family planning (***Medicaid benefit only***)

General Program Overview (continued) – Medicaid and CHIP

Durable Medical Equipment (DME)

- Eligible to obtain DME/Medical Supplies when ordered by a network provider.
- For equipment/supplies costing < $1000 the provider must complete the appropriate Home Health DME/Medical Supplies Physician Order Form.
- Prior authorization is required where the cost of the medical equipment and/or supplies is over $1000.

Refer to Aetna Better Health Provider Manual for more information on DME.

STAR Kids Program Overview

- PCP Selection
- Required or member is “defaulted” to a PCP upon enrollment into a plan
- Specialty care is coordinated through PCP. Please note that members do not need a referral from PCPs to get behavioral health care services.
- Members may access any Aetna Better Health in-network provider
- Members may see any Texas Health Steps (THSteps) provider for THSteps covered services

Lab Services

- Quest Labs
- LABCORP

- Use of contracted radiology facilities

- Precertification required for all inpatient hospitalizations and selected outpatient services

Individuals excluded from participating in STAR Kids include:

- Adults age 21 years or older.
- Children and young adults age 20 and younger enrolled in STAR Health.
- Children and young adults age 20 and younger who reside in the Truman Smith Children's Care Center or a state veteran's home.

STAR Kids Service Coordination

- Aetna Better Health must provide sufficient levels of service coordination to meet the unique needs of members.

- Service coordination are provided by Aetna Better Health nurses and other professionals with necessary skills to coordinate care, and includes but is not limited to:
  - Identification of needs (e.g., physical health, mental health, long-term services and supports).
  - Development of a service plan to address identified needs.
  - Assistance to ensure timeliness and coordinated access to services and providers.
  - Attention to addressing the unique needs of members.
  - Coordinating with other (non-capitated) services as necessary and appropriate.

An Integrated Approach

Provider Responsibilities

Members who may need access to Intellectual and Developmental Disability services and Home and Community Based Services (HCBS) Waiver services should receive and appropriate evaluation and psychometric testing. ECI serves children birth up to three years of age, with developmental delays, disabilities or certain medical diagnoses that may impact development.

- Service Coordination (SC) will work as a team with the member, Legally Authorized Representative (LAR), primary care provider and specialists to arrange all the services and supports that are needed.

- The SC team is the primary point of contact for providers when there are issues or questions about a STAR Kids member and should contact them whenever there are changes in a Member's health status.

- Our STAR Kids member services team will also be able to provider assistance and can be reached at:
  - STAR Kids Tarrant & Dallas - 1.844.787.5437

Home Community Health Services

Services that are provided in the home and community, including, but not limited to:

- Home infusion
- Respiratory therapy
- Visits for private duty nursing (R.N.,L.V.N.)
- Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.).
- Home health aide when included as part of a plan of care during a period that skilled visits have been approved.
- Speech, physical and occupational therapies
- Best practice includes focus on improved outcome for members

STAR Kids Provider Responsibilities

- Treat each member with respect and help ensure member choice in their care
- Report critical event or incidents such as Abuse, Neglect and Exploitation to the State related to LTSS services.
- Alert the Service Coordination Team or Member's dedicated Service Coordinator if you notice a change in the member's condition or situation.

Service Coordination and Transition Planning

- Transition planning, a special feature of STAR Kids, is the process of helping teens and young adults prepare for changes following their 21st birthday.

- Aetna Better Health will begin STAR Kids transition planning when their members turn 15:
  - The Aetna Better Health service coordinator and transition specialist will work closely together to ensure a smooth transition.

Transition planning includes:

- Developing a continuity of care plan
- Coordination to help identify future employment and employment training
- Health and wellness education to assist with self-management
- Identify support system's, help anticipate barriers and opportunities
- Assistance with applying for community services
- Discharge planning and transition of care to long-term facilities

General Program Overview – STAR & STAR Kids

Non-Emergency Medical Transportation (NEMT) Services

Effective June 1st, 2021, Healthcare providers may request Non-Emergency Medical Transportation (NEMT) on behalf of members.

What are NEMT services?

- Access2Care provides transportation to covered health care services for Medicaid Members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. Access2Care does NOT include ambulance trips.

What services are part of Access2Care?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.

General Program Overview (continued)
STAR & STAR Kids

Non-Emergency Medical Transportation (NEMT) Services – Continued

- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be the Member, the Member's family member, friend, or neighbor.
- Members 20 years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain covered health care service. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
- Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

General Program Overview (continued)
STAR & STAR Kids

Non-Emergency Medical Transportation (NEMT) Services – Continued

- If you have a Member needing assistance while traveling to and from his or her appointment with you, Access2Care will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health care services are being provided but may remain in the waiting room during the Member's appointment.
- Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone. Parental consent is not required if the covered health care service is confidential in nature.
- If you have a Member you think would benefit from receiving NEMT services, please refer him or her to Access2Care at **1-866-411-8920** for more information.

General Program Overview (continued)
STAR, CHIP & STAR Kids

- CHIP and STAR both offer many benefits:
  - Dentist visits, cleanings, and fillings
  - Eye exams and glasses
  - Choice of doctors, regular checkups, and office visits
  - Prescription drugs and vaccines
  - Access to medical specialists and mental health care
  - Hospital care and services
  - Medical supplies, X-rays, and lab tests
  - Treatment of special health needs
  - Treatment of pre-existing conditions

For a listing of CHIP benefit limitations, please refer to Aetna Better Health of Texas Provider Manual. ABH TX Provider Manual
https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/texas/providers/pdf/tx_provider_manual.pdf

Texas Agency-Administered Programs and Case Management Services (Additional Resources)

Medicaid and CHIP

- Essential Public Health Services
- Early Childhood Intervention (ECI) Case Management/Service Coordination
- Department of State Health Services (DSHS) Targeted Case Management
- DSHS Mental Health Rehabilitation (Behavioral Health)
- DSHS Case Management for Children and Pregnant Women
- Women, Infants, and Children (WIC) Program
- Department of Assistive and Rehabilitative Services (DARS) Case Management for the Visually Impaired
- Tuberculosis Services Provided by DSHS-Approved Providers
- Department of Aging and Disability (DADS) Hospice Services

Medicaid

- Texas Department of Family and Protective Services (TDFPS)
- School Health and Related Services (SHARS)
- THSteps Medical Case Management
- THSteps Dental (Including Orthodontia)
- THSteps Environmental Lead Investigation (ELI)
- **Non-Emergency Medical Transportation (NEMT)**

***Refer to Aetna Better Health Provider Manual for more information about these programs.**

Environmental Lead Investigation (ELI)

Lead Screening and Testing

- In accordance with current federal regulations, Texas Health Steps requires blood lead screening at ages notated on the Texas Health Steps Periodicity Schedule and must be performed during the medical checkup. Noncapitated.
- Childhood Lead Poisoning Prevention https://dshs.texas.gov/region2-3/Programs/THStepsLead.shtm
- Environmental lead risk assessments, as part of anticipatory guidance, should be completed at all check-ups through age 6 when testing is not mandated, and may be performed using the Lead Risk Questionnaire, Form Pb-110, which is provided at https://dshs.texas.gov/lead/screening.shtm
- The initial lead testing may be performed using a venous or capillary specimen and must either be sent to the DSHS Laboratory or performed in the provider's office using point-of-care testing.
- All blood lead levels in clients who are 14 years of age or younger must be reported to DSHS. Reports should include all information as required on the Child Blood Lead Reporting, Form F09-11709 or the Point-of-Care Blood Lead Testing report Form Pb-111, which can be found at https://dshs.texas.gov/lead/providers.shtm or by calling 1-800-588-1248.

Texas Provider Marketing Guidelines

- The purpose of the Texas Provider Marketing Guidelines is to provide guidance to the State of Texas Medicaid fee-for-service, Medicaid Managed Care, Children's Health Insurance Program (CHIP), Children's Medicaid Dental, CHIP Dental Providers and the STAR Kids program as to what is permissible and prohibited provider marketing.

- The information provided is not intended to be comprehensive, or to identify all applicable state and federal laws and regulations. Providers remain responsible for and must comply with all applicable requirements of state and federal laws and regulations.

Texas Provider Marketing Guidelines

- **Examples of Permissible and Prohibited Marketing Activities**

	Permissible	Prohibited
1	Sending Marketing Materials to every person within a specific zip code, without specifically targeting Medicaid clients.	Unsolicited personal contact such as direct mail, telephone, and door---to---door solicitation.
2	Sending an appointment reminder to a Medicaid client.	Offering gifts or other inducements designed to influence a client's choice of Provider.
3	Participation at a health awareness education event And making available branded giveaways valued of No more than 10 dollars, individually.	Providing giveaways or incentives Valued at over 10 dollars, individually, or passing out materials.
4	General dissemination of Marketing Materials via television, radio, newspaper, Internet, or billboard advertisement.	Dissemination of material or any other attempts to communicate intended to influence the Client's choice of Provider.
5	Provider marketing conducted at: • Community---sponsored educational event • Health fair • Outreach activity or • Other similar community or nonprofit event And which does not involve unsolicited personal contact or promotion of the provider's practice that is not intended as health education.	Sending Marketing Materials to a client to offer inducements or incentives.
6	Provider marketing for the purpose of: • Providing appointment reminder • Distributing promotional health materials • Providing information about the types of services offered by the provider • Coordination of care	Unsolicited personal contact at a child care facility or any other type of facility; or targeting clients solely because the client receives Medicaid/CHIP benefits.

Adoption Assistance and Permanency Care Assistance

Effective September 2017

Aetna Better Health, Texas
Provider Relations Department

Overview: Adoption Assistance and Permanency Care Assistance

What is AAPCA?

- The Adoption Assistance program provides help for certain children who are adopted from foster care.
- The Permanency Care Assistance program gives financial support to family members who provide a permanent home to children who were in foster care but could not be reunited with their parents.

Background

- It was the result of the 83rd Texas Legislature which directed HHSC to move remaining Medicaid fee-for-service clients to Medicaid managed care.
- Currently, Adoption Assistance and Permanency Care Assistance clients receive Medicaid services through Medicaid fee-for-service
- Most of these clients will move to Medicaid managed care September 1, 2017

Managed Care Programs in Texas

- STAR
- STAR Kids

The Adoption Assistance and Permanency Care Assistance program may provide: Medicaid coverage for the child (2) Monthly cash assistance from Department of Family and Protective Services (DFPS); (3) A one-time reimbursement from DFPS for some legal expenses that come with adopting or becoming the managing conservator of a child

What is STAR?

- STAR is a managed care program for most people on Medicaid.
- STAR serves:
  - Children,
  - Low-income families,
  - Former foster care children
  - Pregnant women
- As of Sept. 1, 2017, most children and youth in Adoption Assistance and Permanency Care Assistance will get services through STAR Health.

Which AA/PCA Members Will Be in STAR?

- Adoption Assistance and Permanency Care Assistance clients who meet the following criteria moved to STAR on September 1, 2017.

- Don't get:
  - Supplemental Security Income (SSI)
  - Medicare
  - 1915 (c) waiver services

- Don't have a disability as determined by the U.S. Social Security Administration or the State of Texas.

- Don't live in:
  - A nursing facility
  - An intermediate care facility for individuals with intellectual or developmental disabilities or related conditions (ICF/IID).

What are STAR Benefits?

• **Same Medicaid benefits you have today**	• **Unlimited prescriptions**
• Unlimited necessary days in a hospital	• A primary care provider (main doctor, nurse or clinic) to serve as a medical home
• Value-added services	• Service management for certain members, including Adoption Assistance and Permanency Care Assistance

What is STAR Service Management?

- A service performed by the health plan to do all of the following:
  - Develop a service plan, which includes a summary of current needs, a list of services required, and a description of who will provide those services.
  - Coordinate services among a member's primary care provider, specialty providers and non-medical providers.

- All Adoption Assistance and Permanency Care Assistance managed care members get service management.

What is STAR Kids?

- STAR Kids is a managed care program for children and young adults 20 and younger who meet at least once of the following criteria:
  - Get Supplemental Security Income (SSI) or SSI-related Medicaid
  - Are enrolled in Medicare
  - Get services through a 1915 (c) waiver program
- As of September 1, 2017, children and youth in Adoption Assistance and Permanency Care Assistance who meet the above criteria will get services through STAR Kids.

Which AA/PCA Members Will Be in STAR Kids?

Adoption Assistance and Permanency Care Assistance clients who meet the following criteria have moved to STAR Kids on September 1, 2017.

- Get Supplemental Security Income (SSI)
- Have a disability as determined by the U.S. Social Security Administration or the State of Texas

What are STAR Kids Benefits?

• **Same Medicaid benefits you have today**	• **Unlimited prescriptions**
• Unlimited necessary days in a hospital	• Extra services
• Service Coordination	• A primary care provider (main doctor, nurse or clinic) to serve as a medical home
	• State Plan long-term services and supports, such as private duty nursing and personal care services

What is STAR Kids Service Coordination?

- Specialized care service provided by health plan nurses and other professionals with necessary skills to coordinate care, including:
  - Identification of needs, such as, physical health, mental health,, long-term services and supports.
  - Development of a person-centered service plan to address identified needs
  - Making sure clients get the services they need when they need them
  - Attention to addressing members' unique needs
  - Coordinating with other services when necessary

Continuity of Care

- HHSC requires STAR and STAR Kids health plans to provide "Continuity of Care."

  - Authorizations for basic care such as specialist visits and medical supplies are honored for 90 days, until the authorization expires or until the health plan issues a new one
  - Authorizations for long-term services and supports are honored for six months or until a new assessment is completed
  - During the transition period, members can keep seeing current providers, even if they are out of the health plan's network
  - Providers don't need to resubmit authorization requests to the health plans if an authorization is already in place

How Will I Know What Plan My Patients Are In?

- All STAR and STAR Kids members get a health plan ID card, in addition to a Your Texas Benefits Medicaid card from the HHSC.
- The health plan ID card includes:

  -Member's name and Medicaid ID number

  - Medicaid program (e.g. STAR, STAR Kids)

  - Health plan name

  - Primary care provider name and phone number

  - Toll-free phone numbers for member services, service coordination, and behavioral health services hotline

  - Other information may be provided (e.g. date of birth, service area, Primary Care Provider address)

Will Current Services Be Covered in Managed Care?

- Approved and active prior authorizations for covered services are subject to the ongoing care requirements.
- Providers don't need to resubmit authorization requests to the health plans if an authorization is already in place.

If services are received prior to the approval of transition of benefits, the services must be approved by the Medical Director in order for coverage to be extended at the new Plan level. The Aetna Better Health Medical Management department will coordinate all necessary referrals, or any other authorizations so that the continuity of care is not disrupted.

Value-Added Services - STAR

- 24 Hour Nurse Line
- No Cost Smartphone
- Sports Physicals (ages < 19)
- Weight Management (ages 3 - 19)

- Full List of Services-
- https://www.aetnabetterhealth.com/texas/whats-covered-star.html

Value-Added Services - CHIP

- 24 Hour Nurse Line
- Sports Physicals
- Weight Management (ages 3-19)
- Smoking Cessation (ages 12 and older)
- PROMISE program (pregnant members)

STAR Kids Covered Services

STAR Kids Covered Services

- STAR Kids benefits are governed by the Aetna Better Health of Texas contract with the Health and Human Services Commission (HHSC), and include: medical, vision, behavioral health, pharmacy and long term services and supports (LTSS). MDCP services are covered for individuals who qualify for and are approved to receive MDCP.
- The following chart details the Member benefit package available to Aetna Better Health of Texas STAR Kids Members. Please refer to the current Texas Medicaid Provider Procedures Manual, found at www.tmhp.com at

www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx for the listing of limitations and exclusions

STAR Kids Value Added Services

- Aetna Better Health of Texas STAR Kids has developed several value-added services and extra benefits to provide our members.
- Discount Pharmacy/Over-the-Counter Benefits
- Extra help getting a ride
- Extra Vision services
- Gift Program-STAR Kids Screening and Assessment Instrument
- Inpatient Follow-up Incentive Program
- Well-child exam $25 gift card
- Respite services
- Help with members with asthma
- Temporary Phone Help
- On-line Mental Health Resource https://www.aetnabetterhealth.com/texas/members/behavior
- Texas Health Steps
- Sport Physicals
- Home Visits

STAR Kids MDCP Service Array

- STAR Kids MDCP Waiver
  - Adaptive aids
  - Minor home modifications
  - Transition assistance services
    - Employment Assistance*
    - Flexible family support services*
    - Financial Management Services*
    - Respite services*
    - Supported employment*

- *These services are available through the Consumer Directed Services (CDS) option

Assessments and Authorizations

- ABH is responsible for functional and medical assessments.
- Existing authorizations for LTSS are honored until the end of the current authorization, or until ABH does a new assessment.
- Existing authorizations for acute care services are honored until the end of the current authorization, or until ABH does a new assessment.
- Please visit our website for additional information surrounding our access to care guidelines (STAR Kids)

Covered Services

- The benefits in the Provider Manual show what services Aetna Better Health of Texas and Medicaid Fee-for-Service (FFS) covers.

- STAR Kids integrates the delivery of state plan services, behavioral health services, and LTSS benefits for children and young adults age 20 and younger with disabilities.

- Main features include service coordination, a comprehensive needs assessment, and client-centered planning and service design.

Covered Services

- Aetna Better Health is responsible for authorizing, arranging, coordinating, and providing services including:
  - Medically necessary covered services
  - Functionally necessary covered services

- Aetna Better Health will provide full coverage for necessary covered services beginning on the date of the member's enrollment and regardless of:
  - Pre-existing conditions
  - Prior diagnosis
  - Health status; or
  - Any other factor

Long-Term Supports and Services

- LTSS available under the state plan for STAR Kids members includes:
  - Private duty nursing (PDN)
  - Personal care services (PCS)
  - Community First Choice (CFC)

- MDCP waiver services, available to members who meet income, resource, and medical necessity requirements for nursing facility level of care, include:

  - Services unavailable under the state plan, as a cost-effective alternative to living in a nursing facility.

Long-Term Supports and Services

- PDN services include nursing and caregiver training and education, and must be available to all members determined eligible through the STAR Kids Screening and Assessment Instrument (SK-SAI).

- PCS must be available to members who require assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), or health maintenance activities (HMAs) because of a physical, cognitive, or behavioral limitation related to the members disability or chronic health condition, and PCS services must be authorized through the SK-SAI.

- Aetna Better Health will ensure members who receive PDN, PCS, or both, have access to appropriate providers .

Long-Term Supports and Services

- Aetna Better Health will provide functionally necessary CFC services for qualifying members, which include:
  - » Personal care services (attendant care)
  - » Acquisition, maintenance, and enhancement of skills (habilitation)
  - » Emergency response services
  - » Support management
- All CFC services are provided in a community-based setting.
- MDCP provides services to:
  - Support families caring for children and young adults who are medically dependent.
  - Encourage de-institutionalization of children in nursing facilities.

Long-Term Supports and Services

- STAR Kids MDCP Waiver
  - Adaptive aids
  - Minor home modifications
  - Transition assistance services
  - Employment Assistance*
  - Flexible family support services
  - Financial Management Services*
  - Respite services*
  - Supported employment*

- *These services are available through the Consumer Directed Services (CDS) option

Long-Term Supports and Services

Assessments and Authorizations

- Aetna Better Health will assess the need for PCS, PDN, CFC, and MDCP.
- Aetna Better Health is responsible for functional and medical assessments.
- Existing authorizations for LTSS are honored for 6 months, until the end of the current authorization, or until Aetna Better Health does a new assessment.
- Existing authorizations for acute care services are honored for 90 days, until the end of the current authorization, or until Aetna Better Health does a new assessment.

What is EVV?

EVV (Electronic Visit Verification) is a computer-based system that electronically documents and verifies service delivery information, such as date, time, service type and location, for certain Medicaid service visits.

EVV system must capture the following data elements:

- The Member receiving the services
- The Attendant providing those services
- The Location of service delivery
- Date of the service delivery
- Time that the attendant/staff begins and ends service delivery

ABH will not pay an EVV claim without a matching EVV visit transaction.

EVV is required for PCS services. Please refer to the link below for a complete list of PCS required to use EVV.

https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/programs-services-required-evv.pdf

EVV Participant Roles & Responsibilities

Program provider- is an entity that contracts with HHSC or an MCO to provide an EVV service. A Program provider is the Provider agency/ Financial Management Services Agency (FMSA)

Responsibilities include, but are not limited to:

- Following all EVV requirements described in:
  - The EVV Policy Handbook
  - Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter O
- Adhering to policies and requirements of their Medicaid program
- Meeting other applicable HHSC and MCO requirements
- Completing all required EVV training
- Using the EVV system
- Training service providers on the use of EVV
- Ensuring service providers use the EVV system to clock in at the beginning of service delivery and clock out at the end of service delivery
- Managing program provider, service provider and member data within the EVV system

EVV Participant Roles & Responsibilities- Continued

EVV Proprietary System Operator (PSO) is a program provider or FMSA that uses an HHSC-approved EVV proprietary system.

EVV PSO responsibilities include, but are not limited to:

- Adhering to all HHSC EVV Business Rules for Proprietary Systems
- Following all EVV requirements described in:
  - The EVV Policy Handbook
  - Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter O
  - Texas Government Code Section 531.024172 or its successors
- Supporting one or more clock in and clock out methods
- Providing EVV system training and technical support

EVV Participant Roles & Responsibilities- Continued

Member/Consumer Directed Services (CDS)- is a member or legally authorized representative (LAR) who participates in the CDS option.

CDS employer responsibilities include, but are not limited to:

- Completing all required EVV training
- Training their CDS employees on the use of the EVV system
- Ensuring CDS employees use the EVV system to clock in when services begin and clock out when services end
- Approving time worked
- Signing up for GovDelivery to receive the most current news and alerts related to EVV

EVV Participant Roles & Responsibilities- Continued

EVV Vendor- is contracted with the state's claims administrator to provide a cost free EVV system for program providers and FMSAs.

- EVV vendor responsibilities include, but are not limited to:
  - Adhering to all HHSC EVV vendor business rules for system operation and functionality
  - Following all EVV requirements described in:
    - The EVV Policy Handbook
    - Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter O
    - Texas Government Code Section 531.024172 or its successors
- Supporting multiple clock in and clock out methods
- Providing EVV system training and technical support

EVV Participant Roles & Responsibilities- Continued

Payers are responsible for paying Medicaid claims, administering the EVV program and enforcing EVV requirements. In Texas, the payers are HHSC and the MCOs.

Payer responsibilities include, but are not limited to:

- Following state and federal requirements when processing claims for services required to use EVV
- Developing EVV policies, processes and procedures
- Providing EVV policy training to program providers, FMSAs and CDS employers
- Conducting EVV compliance reviews of program providers, FMSAs and CDS employers

HHSC requires EVV for Medicaid personal care services authorized by the following HHSC programs

- Long-term Care (LTC) Fee-for-Service (FFS)
- Acute Care FFS
- Managed Care

HHSC is the payer for LTC and acute care services administered by the state, known as FFS. Acute care payments are made by TMHP on behalf of HHSC.

EVV Participant Roles & Responsibilities- Continued

Aggregator (TMHP)

Texas Medicaid and Healthcare Partnership (TMHP**)** is the state's claims administrator and is responsible for the Medicaid Management Information System (MMIS) where the EVV Aggregator resides. TMHP is also responsible for the EVV Portal, the EVV vendor pool and coordinates all data exchange for EVV systems

TMHP responsibilities include, but are not limited to, the following:

- Processing claims for EVV services, including forwarding claims to MCOs
- Paying claims for Acute Care FFS on behalf of HHSC
- Managing the EVV Aggregator and EVV Portal
- Selecting and managing the approved EVV vendors on behalf of HHSC
- Training on the EVV Portal

How Does EVV Work?

When an attendant provides services to a member at home or in the community, the attendant will use one of three approved EVV time recording methods to clock in and out when service delivery occurs:

- Mobile Application
- Alternative Device
- Member's Home Phone Landline

EVV Training Policy

Program Providers and Financial Management Service Agencies (FMSAs) must take the following training:

HHSC-approved EVV vendor training conducted by the EVV vendor

- Link to HHSC trainings: https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification/evv-training-resources

TMHP EVV Aggregator and EVV Portal training conducted by TMHP

- Link to TMHP training: https://www.tmhp.com/topics/evv/evv-training

Aetna offered EVV Policy training

- Aetna website: https://www.aetnabetterhealth.com/texas/providers/electronic-visit-verification.html

Providers must train with HHSC , TMHP or Aetna, however, they are not required to train with each MCO plan separately.

EVV Training Policy- continued

EVV training is provided in a variety of formats; including, but not limited to:

- Computer-based training
- Instructor-led training
- Webinars

EVV vendor access will not be granted until the EVV vendor training has been completed.

If the current program provider changes EVV vendors, the EVV vendor training must occur prior to using the new HHSC approved EVV System.

Vendor training is Mandatory as well as TMHP Portal training!

EVV Visit Transaction

An EVV visit transaction is a record generated by an EVV system that contains data elements for an EVV visit.

The EVV visit transaction includes:

- Service authorization data
- Member data
- Service provider data
- Program provider or FMSA data
- EVV service delivery data

Breakdown of Required EVV Data Elements

Visit Data Category	Required Elements to Verify the Visit
The Provider Agency:	• Taxpayer Identification Number (TIN) • National Provider Identifier (NPI) or Atypical Provider Identifier (API) • Texas Provider Identifier (TPI) (only applicable in Fee-For-Service) • Providers Legal name • Provider address, city, zip
Type of Service Rendered:	• Service Authorization Information • HCPCS Code and Modifiers
The Member receiving the service:	• First and Last Name • Medicaid ID • DOB • Address, City & Zip Code • Landline Phone Number (if applicable) • Medicaid Eligibility Start & End • Payer (Aetna) • HHS Contract Number(s) • Payer Plan Code (MCO Service Delivery Area) • EVV Client ID (assigned by EVV vendor)
The Date and Time of the Services:	• Actual Date In & Date Out • Actual Clock In & Clock Out
The Location of Service Delivery:	• GPS Coordinates of clock in and out only (if using mobile method) • Caller ID (Landline) • Token ID (Alternative Device)
The Individual providing the service:	• Employee First and Last Name • Phone Number (if applicable) • EVV Worker ID (assigned by the EVV vendor) • Employee Start Date (start date of employment with provider) • Employee End Date (end date of employment with provider)

EVV Aggregator Validation

The EVV Vendors will use data from the EVV Aggregator to validate the following:

- Provider contract/enrollment information
- Member eligibility
- Member authorization

EVV vendors are required to notify contracted providers/FMSAs when mismatches are identified.

Reminder: The EVV Aggregator is a centralized database that collects, validates, and stores statewide EVV visit data transmitted by an EVV system. Providers should be aware that EVV Aggregator validation and claims EVV visit matching does not guarantee claims reimbursement. Other standard claims review, audits and edits will be considered for claims payment as usual.

Identification Data

Before an attendant can provide an initial service to a member, certain identification data must be in the EVV system for the contracted provider or FMSA:

Some examples of identification data include:

- Contracted Provider/FMSA
  - NPI or API
  - TIN
- Member/CDS employer
  - Medicaid ID
  - Date of Birth
- Attendant
  - Name
  - EVV Worker ID

EVV Visit Transaction Data

Along with Identification Data, the following Visit Transaction Data is captured by the EVV system:

- Clock in at the beginning of service delivery using an approved clock in and clock out method.
- Clock out at the end of service delivery using an approved clock in and clock out method.

- Visit Date of the services

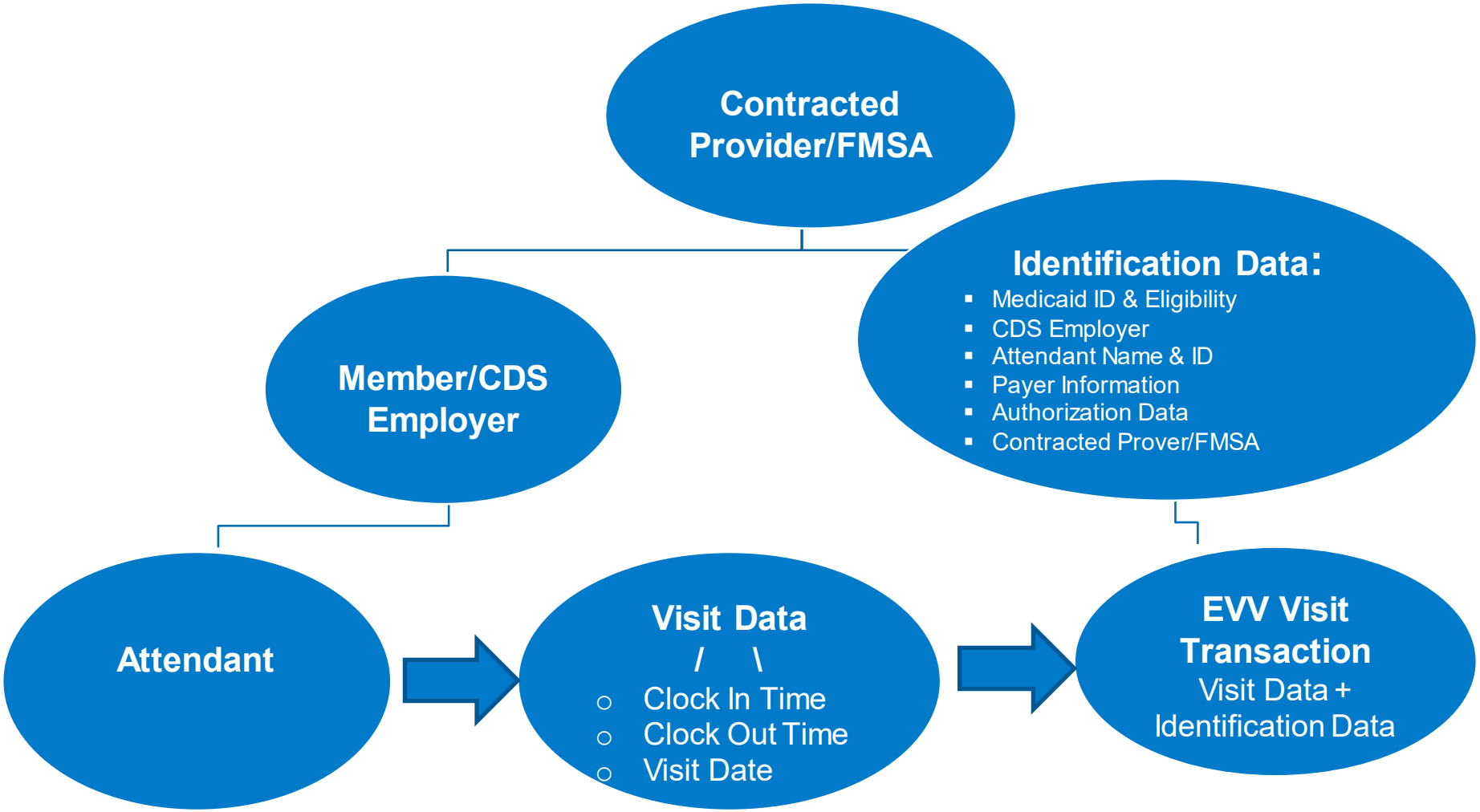
Visit Transactions

- An EVV visit transaction is a complete & verified visit that consists of all the required data elements needed to verify a service delivery visit.

- An EVV visit transaction may also be created manually if an attendant was unable to clock in and/or clock out of the system. This is referred to as a Graphical User Interface (GUI) visit transaction.

- Once the provider agency/CDS employer verifies the data elements associated to a visit transaction are correct, and the EVV vendor system performs required validation edits, the transaction is then exported to the EVV Aggregator.

EVV Visit Transaction Flow Chart



EVV – Clock In/Clock Out Methods

A service provider or CDS employee must use an HHSC-approved clock in and clock out method to begin and end service delivery when providing EVV services to a member in the home or the community.

EVV vendors offer the following three HHSC-approved clock in and clock out methods:

- **Mobile method**
- **Home phone landline**
- **Alternative device**

A PSO must offer one or more of the three HHSC-approved clock in and clock out methods listed above.

The PSO or EVV Vendor must provide access to clock in and clock out methods at no cost to the member, program provider, FMSA, CDS employer, service provider, HHSC, MCO or TMHP.

EVV – Clock In/Clock Out Methods-continued

If the clock in and clock out method malfunctions, the EVV system must allow the program provider, FMSA or CDS employer to manually enter EVV visits.

When the service provider or CDS employee clocks in and clocks out using an HHSC-approved method, the EVV system captures the following visit data:

- The type of service provided (Service Authorization Data)
- The name of the recipient to whom the service is provided (Member Data)
- The date and times the provider began and ended the service delivery visit
- The location, including the address, where the service is provided
- The name of the person who provided the service (Service Provider Data)

EVV Mobile-Clock in/Clock out Method

A service provider or CDS employee may use the mobile method for clocking in and out of the EVV system in the home or in the community. Each EVV vendor and PSO, if applicable, will supply a downloadable application for use on a smart phone or device with Internet connectivity.

If a service provider or CDS employee clocks in or out within 250 feet (EVV allowed geo-perimeter) of the member's home, the default service delivery location is the member home. The service provider or CDS employee can select a different service delivery location if necessary.

If the service provider or CDS employee clocks in or out beyond the 250-foot EVV allowed geo-perimeter, the service provider or CDS employee must select a service delivery location.

Service Delivery Location options include:

- Member Home
- Family Home
- Neighbors Home
- Community
- Other

EVV Mobile-Clock in/Clock out Method

If the service provider or CDS employee clocks in at the home, delivers services in the community and then clocks out at the home, the service delivery location would be member home.

Service providers may use their own personal smart phone or tablet, or a smart phone or tablet issued by the program provider.

Service providers must not use a member's personal smart phone or tablet to clock in and clock out of the EVV system.

CDS employees may use:

- Their own personal smart phone or tablet
- A smart phone or tablet issued by the FMSA
- A smart phone or tablet owned by the CDS employer, if permission is granted.

The mobile method is the only clock in and clock out method the service provider or CDS employee may use when delivering EVV services in the community or when traveling out of state. Contact your program representative to determine if your service provider or CDS employee may deliver EVV services while the member is out of state.

EVV Mobile-Clock in/Clock out Method

The mobile method:

- Utilizes a secure login function for each user.
- Records the specific location at the exact time of clocking in and clocking out.
- Does not track location before clocking in, during service delivery or after clocking out.
- Does not use mobile device plan minutes and only uses minimal data.
- Does not store Protected Health Information (PHI) on the mobile device.
- Can be used when an internet connection or a cellular network is not available.

Note: EVV vendors cannot share or sell location data.

Clock in and clock out requirements:

- The program provider or FMSA must set up the mobile method in the member's profile.
- The mobile device must be operational to use the mobile method. For example, the phone must be working, and the battery charged.

EVV **Mobile Method** cont'd

Service providers and CDS employees:

- Must follow instructions from their program provider, FMSA or CDS employer to download and activate the mobile application.
- Must obtain their own unique login credentials from their program provider, FMSA or CDS employer.
- Must only access the mobile application using their own login credentials.
- Must **not** share mobile application login credentials.
- May share the same mobile device for clocking in and clocking out of the EVV system for the same member using their own mobile application login credentials.

The program provider, FMSA or CDS employer may contact their EVV vendor or PSO, if applicable, for a full list of mobile application specifications, including supported mobile devices.

HHSC, TMHP, EVV vendors and MCOs are not liable for:

- Any cost incurred while using the mobile method.
- Any viruses on the mobile device.
- A hacked, broken, damaged, lost or stolen mobile device.
- A non-working mobile device.

EVV Landline-Clock in/Clock out Method

The service provider or CDS employee may use the member's landline, if the member agrees, for clocking in and clocking out of the EVV system. They do this by calling the EVV vendor's or EVV PSO toll-free number.

If a member does not agree to allow the service provider or CDS employee to use their landline or if the member's landline is frequently not available for the service provider or CDS employee to use, the service provider or CDS employee must use another approved clock in and clock out method.

Landline Requirements

Program providers and FMSAs must follow the instructions from the vendor or EVV PSO to set up the landline.

- The landline must be the member's home phone landline number or a landline in another location that the member frequently receives services, such as a family member's home or a neighbor's home.
- The owner of the landline must give permission to the member and the service provider or CDS employee to use the telephone for EVV.
- The phone must be a landline phone. It must not be an unallowable landline phone type. See Unallowable Landline Phone Types.

EVV Landline-Clock in/Clock out Method

Program Providers and FMSAs are responsible for initial setup and maintenance of the landline in the EVV system. The program provider or FMSA must:

Enter the member's landline number in the EVV system before the service provider or CDS employee can use the landline to clock in and clock out.

Enter one or more landline number if the member frequently receives services in an alternate location.

Verify the landline number using the *EVV Landline Phone Verification Report* located in the EVV system.

Ensure the landline number(s) listed in the member's profile are current.

The program provider or FMSA must update the member's profile in the EVV system if the landline number used for clocking in and clocking out does not match.

EVV Landline-Clock in/Clock out Method

Unallowable Landline Phone Type

An unallowable landline phone type is a mobile phone number or cellular enabled phone number. Phones used to clock in or clock out through the landline method must be a landline phone, and **not** a cellular phone or device.

Unallowable landline phone types include:

- Cellular phones
- Cellular enabled devices such as tablets and smart watches

Numbers from phone carriers such as Cricket, that provide mobile phone services only will always be identified as an unallowable phone type.

Note: If the service provider or CDS employee wants to use a cell phone or tablet, they must use the mobile method.

EVV Landline-Clock in/Clock out Method

Identification of an Unallowable Landline Phone Type

Program providers, FMSAs and CDS employers must use the *EVV Landline Phone Verification Report* in the EVV system to identify an unallowable landline phone type as "mobile". Payers will also use this report to conduct EVV Landline Phone Verification Reviews, refer to 10020 EVV Landline Phone Verification Reviews.

If the program provider, FMSA, CDS employer or payer identify an unallowable phone type, action must be taken.

Program Provider Required Actions

When an unallowable phone type is identified, program providers must either:

Verify and document that the phone type is an allowable phone type; or

Remove the unallowable landline phone type from the EVV system as the member's home phone landline and ensure a valid landline or another approved clock in and clock out method is used.

Program providers must follow any actions required by the payer in a notice of non-compliance.

EVV Landline-Clock in/Clock out Method

FMSA and CDS Employer Required Actions

When an unallowable phone type is identified, FMSAs must notify the CDS employer that the phone number is an unallowable landline phone type and:

- Work with the CDS employer to verify and document that the phone type is an allowable phone type; or
- Remove the unallowable landline phone type from the EVV system as the member's home phone landline and work with the CDS employer to ensure a valid landline number or another approved clock in and clock out method is used.

When an unallowable phone type is identified, CDS employers must take one of the following actions:

- provide documentation to the FMSA demonstrating the current landline number is an allowable phone type;
- provide a valid landline number to the FMSA; or
- choose another approved clock in and clock out method for the CDS employee to use and inform the FMSA of the new method.

FMSAs and CDS employers must follow any actions required by the payer in a notice of non-compliance.

EVV Landline-Clock in/Clock out Method

Documentation

When requested by the payer, program providers and FMSAs must provide documentation to:

- demonstrate that the phone number is from an allowable phone type; or
- demonstrate that that the service provider or CDS employee is no longer using an unallowable landline phone type.

Examples of documentation from an external source showing that the phone number is an allowable landline phone type, may include but not limited to screenshots or printouts from:

- White Pages
- Free Carrier Look-up Service
- Reverse Phone Check

EVV Landline-Clock in/Clock out Method

If the phone number is from an unallowable phone type, program providers and FMSAs must provide documentation showing the service provider or CDS employee is no longer using an unallowable landline phone type. Acceptable documentation includes one of the following:

- A screenshot of the member profile reflecting another approved clock in and clock out method is used.
- Verification from the EVV system showing that an alternative device was ordered for the member, if applicable.

EVV Alternate Device-Clock in/Clock out Method

An alternative device is an HHSC-approved electronic device that allows a service provider or CDS employee to clock in and out of the EVV system from the member's home.

A program provider, CDS employer or service provider must explain to the member the purpose of the alternative device and how the alternative device works.

The alternative device produces codes that identify the precise date and time service delivery begins and ends. Codes from alternative devices, provided by EVV vendors, expire seven days from the date of the EVV visit. Codes from alternative devices must be entered in to the EVV system before they expire by calling a toll-free number provided by the EVV vendor.

The service provider or CDS employee may use any phone type to call the toll-free number and enter the alternative device codes. However, service providers or CDS employees should never use or request to use the member's mobile phone unless the member is a CDS employer and the CDS employer has given the CDS employee permission to use the CDS employer's mobile phone.

EVV Alternate Device-Clock in/Clock out Method

The program provider or FMSA must document in the member's case file each time the alternative device is damaged or lost. The program provider, FMSA or CDS employer must also order a new alternative device or ensure another clock in and clock out method is used.

If the alternative device was damaged or lost by a member then the program provider, FMSA or CDS employer is responsible for requesting:

- An interdisciplinary team (IDT) meeting.
- A service planning team (SPT) meeting.
- A child and family team (CFT) meeting or a meeting with the member, their LAR and any natural or formal support to discuss the use of the alternative device with the member.

EVV Alternate Device-Clock in/Clock out Method

Failure to document a lost or damaged alternative device in the member's case file or schedule an IDT, SPT or CFT meeting with the member may result in the payer or the EVV vendor holding the program provider or FMSA responsible for the lost or damaged alternative device.

The alternative device must always remain in the member's home even during an evacuation. If the alternative device does not remain in the home, the payer may make a Medicaid fraud referral to the HHS Office of the Inspector General.

Note: A PSO may offer different types of alternative devices. All alternative devices must support the collection of critical data elements. HHSC must approve any alternative device used by the PSO before use.

EVV Alternate Device-Clock in/Clock out Method

Ordering an Alternative Device from an EVV vendor

Once the program provider, FMSA or CDS employer has determined a member needs an alternative device, they have 10 business days to order an alternative device from the EVV vendor.

Program providers, FMSAs on behalf of a CDS employer, or CDS employers can order an alternative device through an EVV vendor. The EVV vendor will provide instructions on how to order a device.

The EVV vendor has 10 business days to process and ship the alternative device to the requestor upon receipt of a complete order. Depending on the shipping method, it may take additional days to deliver the order.

If a clock in or clock out method is not available for the service provider or CDS employee to use prior to the delivery of an alternative device, the service provider or CDS employee must manually document the EVV visit and submit service delivery documentation to the program provider or FMSA. The program provider or FMSA must manually enter visit data in the EVV system within the visit maintenance time frame.

EVV Alternate Device-Clock in/Clock out Method

Using the EVV vendor electronic ordering method, program providers, FMSAs on behalf of CDS employers, or CDS employers can:

- Order a new or replacement alternative device
- Track orders for the alternative device
- Manage, assign and un-assign alternative devices
- Manage shipping addresses

If a member does not want an alternative device in their home and another HHSC- approved clock in and clock out method is not available:

- The program provider or FMSA must document the reason in the member's case file.
- An IDT, SPT or CFT meeting must be conducted.

EVV Alternate Device-Clock in/Clock out Method

Installing an Alternative Device

The program provider, CDS employer, service provider or CDS employee must:

- Ask the member where to place the alternative device in the member's home. The alternative device:
  - Should be in a location where it is always accessible to the service provider or CDS employee.
  - May be attached using a zip tie.
  - Must not be mounted in a location that may be dangerous to a member or cause damage to the member's home.
- Install the alternative device by placing the device in the member's home for use by the service provider or CDS employee.

Examples of places where the alternative device may be located in the member's home:

- Kitchen counter
- Coffee table
- Lockbox located in the garage or on the patio

EVV Alternate Device-Clock in/Clock out Method

Malfunctioning Alternative Device

The service provider or CDS employee must notify the program provider or CDS employer immediately if the alternative device malfunctions or fails to generate codes.

When the service provider or CDS employee notifies the program provider or CDS employer the alternative device has malfunctioned:

- The service provider or CDS employee must manually document the EVV visit and submit service delivery documentation to the program provider, FMSA or CDS employer for manual entry of an EVV visit. Refer to 1400 Failure to use an EVV System.
- The program provider, FMSA or CDS employer must contact the EVV vendor or PSO to report the malfunctioning device and order a replacement alternative device.

Equipment provided by an HHSC-approved EVV vendor, must be returned when the equipment is no longer used.

Clocking In & Out Method cont'd

A visit record is created with the clock in and clock out time. Once the visit record has been completed, verified, and confirmed the following data is used to create an EVV visit transaction:

- Contract Provider identification data
- CDS employer identification data
- Member identification data
- Attendant identification data
- EVV visit data

Please Note!

Cell phones are not allowed to be used in place of a home phone landline, unless you are a CDS employer*. If a home landline is not available, the provider agency will have to select either an alternative device or mobile method be used for that member.

*CDS employers are allowed to let their attendants use the CDS employer's cell phone for clocking in and clocking out of the EVV system.

EVV Visit Maintenance

Visit maintenance is the process used by the program provider, FMSA or CDS employer to correct an EVV visit transaction in the EVV system to accurately reflect the delivery of service.

Program providers, FMSAs or CDS employers must complete all required visit maintenance. They must also ensure the EVV Aggregator accepts the visit transaction before the program provider or FMSA submits an EVV claim. If more visit maintenance is completed after submitting an EVV claim, program providers or FMSAs must submit an adjusted claim to match the updated visit transaction.

If the program provider or FMSA submits an EVV claim before required visit maintenance is complete, a payer may deny or recoup the EVV claim as part of contract oversight.

EVV Visit Maintenance-cont'd

If the program provider or FMSA delegates visit maintenance responsibilities to a:

- Third party such as a subcontractor, the program provider or FMSA is always responsible for actions taken by the third party.
- Third party, the program provider or FMSA ensures the third party follows all privacy and security protocols, including when the subcontractor or third-party accesses EVV data.

If CDS employers delegate visit maintenance responsibilities to their designated representative (DR), the CDS employer is responsible for any actions taken by their DR. They must ensure that the DR follows all privacy and security protocols, including when the DR accesses EVV data.

Required Visit Maintenance

Program providers, FMSAs or CDS employers must complete visit maintenance when the:

- EVV system cannot “auto-verify” a visit transaction.
- EVV system identifies exceptions and critical errors.
- EVV Aggregator rejects the EVV visit transaction due to incorrect or missing data.
- Program provider, FMSA or CDS employer reduces bill hours after the EVV system auto-verifies the EVV visit transaction.
- EVV system is unavailable.
- Service provider or CDS employee fails to use the EVV system.

Exceptions are identified by an EVV system and prevent an EVV visit transaction from being auto-verified or sent to the EVV Aggregator.

Auto-Verification

Each time a service provider or CDS employee clocks in or clocks out during service delivery, the EVV system will:

- Capture visit data.
- Verify the clock in and clock out method.
- Compare critical data elements, including schedule data if applicable, in the EVV system.

If all visit data and identification data in the EVV system match, the system auto-verifies the EVV visit transaction which means there were no exceptions found.

If an EVV visit transaction is missing a clock in or a clock out and requires manually entered visit data, or if the data captured at the time of clock in or out does not match the critical data elements in the EVV system, the system cannot auto-verify an EVV visit transaction and will notify the program provider, FMSA or CDS employer of an exception.

Auto-Verification Cont'd

Clearing Exceptions

The EVV system may generate one or more exceptions when the system cannot auto-verify the visit data captured at the time of clock in or clock out.

To clear an exception, program providers, FMSAs or CDS employers must complete visit maintenance in the EVV system by:

- Updating the identification or visit data for a member, if applicable. Refer to 4400 Data Collection for more information.
- Selecting the most appropriate EVV reason code(s), if required.
- Confirming the EVV visit.

Selecting the most appropriate EVV reason code(s) explains the reason for completing visit maintenance. The process involves:

- Selecting an EVV Reason Code Number.
- Selecting an EVV Reason Code Description.
- Entering required free text, if applicable.

Refer to Current HHSC EVV Reason Codes for more information.

Auto-Verification Cont'd

The following are some examples that describe when the EVV system will not auto-verify an EVV visit:

- Clock in or out time is missing
- Clock in or out time does not match a schedule entered in the EVV system
- An EVV visit is manually entered in to the EVV system
- Service providers or CDS employees' clock in or clock out using a landline phone not registered in the member's profile

Auto-Verification without a Schedule

If no schedule is entered in the EVV system, the EVV system will validate the following critical data elements:

- Identity of the service provider or CDS employee
- Identity of the member
- Actual hours worked
- Clock in and out method(s)
- Service type for the visit

If the above data elements match the data in the member's profile, the visit will auto-verify without exceptions.

If any of the above data elements do not match, the EVV system will not auto-verify the EVV visit and visit maintenance must be completed.

EVV System Validation

Once the EVV system has verified a visit, it will conduct more system validation checks on the EVV visit transaction before sending the EVV visit transaction to the EVV Aggregator.

The EVV system validation ensures the identification data and visit data is in the correct format. It compares the critical data elements to Texas Medicaid data stored at TMHP.

An EVV system must perform the following validation before sending an EVV visit transaction to the EVV Aggregator:

- Verifies that no required visit data elements are missing.
- Verifies that all required visit data elements are in the correct format (length, alphanumeric, only valid values).
- Verifies that all required identification data elements are in the correct format (NPI, API, Provider Number).
- Verifies the service group and service code or HCPCS and modifier combination is valid for the member or EVV visit transaction.

If an EVV visit transaction fails the system validation, the EVV system will:

- Not send the EVV visit transaction to the EVV Aggregator.
- Notify the program provider, FMSA or CDS employer of the exceptions that must be corrected.

To clear EVV system validation exceptions, the program provider, FMSA or CDS employer must complete visit maintenance. Once the program provider, FMSA or CDS employer clears the exceptions, the EVV system will send the EVV visit transaction to the EVV Aggregator for final processing.

EVV Aggregator Validation

The EVV Aggregator performs many validations of all data elements on the EVV visit transaction. The EVV Aggregator validations include verifying the:

- NPI or API for the program provider or FMSA to ensure it is active for the visit date.
- Provider number is valid for the NPI or API on the visit date.
- Member's payer matches the Medicaid data.
- Member has Medicaid eligibility for the visit date.
- Service group, service code or HCPCS and Modifier on the visit date.

Based on the above validations, the EVV Aggregator will either accept or reject the EVV visit transaction received from an EVV system then display the status in the EVV Portal.

After the EVV Aggregator accepts an EVV visit transaction, the program provider or FMSA can submit an EVV claim associated with the EVV visit transaction.

When the EVV Aggregator rejects an EVV visit transaction, the EVV Aggregator returns the EVV visit transaction to the EVV system with the reason for the rejection. The program provider, FMSA or CDS employer must complete visit maintenance. After visit maintenance is complete the program provider or FMSA must resubmit the EVV visit transaction to the EVV Aggregator.

Visit Maintenance Time Frame

Program providers, FMSAs and CDS employers must complete all required visit maintenance, including entry of manual EVV visits, within 95 days from the date of service delivery. This is known as the visit maintenance time frame. HHSC may extend the visit maintenance time frame as needed.

After the visit maintenance time frame has expired, the EVV system locks the EVV visit transaction and program providers, FMSAs or CDS employers may only complete visit maintenance if the payer approves a Visit Maintenance Unlock Request.

- A Visit Maintenance Unlock Request, when approved, allows a program provider, FMSA or CDS employer the opportunity to correct data element(s) on an EVV visit transaction(s) after the visit maintenance time frame has expired.

- The program provider, FMSA or CDS employer may request a payer unlock EVV visit transaction(s) for visit maintenance. If a request is submitted by an FMSA, the FMSA must ensure the CDS employer approves any corrections to time worked. If the request is submitted by a CDS employer, the CDS employer must notify their FMSA in writing (e.g., email).

- Approvals and denials of Visit Maintenance Unlock Requests are at the payer's discretion and are determined on a case-by-case basis based on EVV policy or EVV system error. If the request is submitted by the CDS employer and the payer has approved or denied the request, the payer must also notify the FMSA in writing (e.g., email).

- Payers will only approve requests to manually enter and export an EVV visit after the visit maintenance time frame if:
  - The program provider was unable to manually enter and export an EVV visit during the visit maintenance time frame because of a payer or EVV vendor system error, and the error was not resolved within the visit maintenance time frame.
  - The CDS employer, or the FMSA on behalf of the CDS employer, was unable to manually enter and export an EVV visit during the visit maintenance time frame because of a payer, EVV vendor system, or EVV proprietary system error, and the error was not resolved within the visit maintenance time frame.
  - HHSC determines an exception is required for circumstances such as a natural disaster.
- When submitting a Visit Maintenance Unlock Request to create a manual visit due to a payer or EVV system error, the program provider, FMSA or CDS employer must provide evidence demonstrating:
  - They informed the payer of the error within the visit maintenance time frame.
  - The error was not resolved during the visit maintenance time frame.
  - They made a good faith effort to comply with the visit maintenance time frame.
- Making corrections to EVV visit transactions during a LTC FFS contract monitoring review or after it has occurred will not change any type of contract action such as recoupment or settlement reviews taken as result of the LTC FFS contract monitoring review.

Visit Maintenance Unlock Request Process

Program providers, FMSAs and CDS employers must complete the Visit Maintenance Unlock Request specific to their payer and service delivery option found on their payer's website.

Emails with a completed Visit Maintenance Unlock Request must be sent securely to the ABH EVV Mailbox (evvmailbox@aetna.com. Email is to include a contact name, email address and phone number.

The program provider or FMSA can only select the following items from the 'Incorrect Data Element' column of their Visit Maintenance Unlock Request to be unlocked for correction:

- Bill Hours
- Contract Number
- Employee ID
- HCPCS Code/Modifier
- Member Medicaid ID
- NPI/API
- Reason Code

* Payer
* Service Code
* Service Group
* Units
* Visit Location
* N/A – Export Only

Visit Maintenance Unlock Request Process cont'd

The CDS employer can only select the following items from the 'Incorrect Data Element' column of their Visit Maintenance Unlock Request to be unlocked for correction:

- Bill Hours
- Employee ID
- HCPCS Code/ Modifier
- Member Medicaid ID
- Payer
- Reason Code
- Service Code
- Service Group
- Units
- Visit Location
- N/A – Export Only

Visit Maintenance Unlock Request Process cont'd

Initial Request to Payer

Payers must process Visit Maintenance Unlock Requests after receiving a secure and complete request from the program provider, FMSA or CDS employer within the following time frames:

- Ten business days
- Thirty business days if the request was submitted as supporting documentation for a MCO claims appeal

Email requests not sent securely will result in the payer denying the request due to a violation of the Health Insurance Portability and Accountability Act.

Contact the payer for assistance with sending a secure email request.

Payer Request for More Information

The payer may request more information from the program provider, FMSA or CDS employer, the request must be fulfilled within the following time frames of receipt:

- Ten business days
- Fifteen business days if the request is part of a MCO claims appeal.

If the program provider, FMSA or CDS employer does not fulfill the request within the established time frames, the payer may deny the request and a new Visit Maintenance Unlock Request must be submitted.

Visit Maintenance Unlock Request Process cont'd

Payer Denial of Request

If the payer denies the request, the payer must notify the program provider, FMSA or CDS employer through email with the reason for the denial. The email notification must include at a minimum the following information on how to:

- Submit a new Visit Maintenance Unlock Request
- Request a claims appeal, if applicable
- Submit a formal complaint against the payer

Payers may automatically deny a Visit Maintenance Unlock Request if the request:

- Was not sent through a secure method
- Is incomplete or missing required information
- Could not be unencrypted
- Was submitted using an outdated or modified version of the Visit Maintenance Unlock Request

Payer Approval of Request

If the payer approves the Visit Maintenance Unlock Request, the payer will send the approved Visit Maintenance Unlock Request to the EVV vendor or PSO.

Only approved items on the Incorrect Data Element column of the Visit Maintenance Unlock Request will be unlocked for editing.

EVV vendors or PSOs must only allow changes to the items approved by the payer.

Visit Maintenance Unlock Request Process cont'd

Payer Incorrect, Incomplete or Retroactive Authorization Approvals

The payer must approve the Visit Maintenance Unlock Request when:

- The payer previously provided incorrect or incomplete information on the prior authorization for a member and the updated authorization requires updates to EVV visit transactions outside of the EVV visit maintenance time frame.
- The payer submits a retroactive authorization for a member that will require the program provider, FMSA or CDS employer to resubmit an EVV visit transaction or EVV claim outside of the EVV visit maintenance time frame.
- HHSC directs the payer to approve within the initial request time frame specified in this policy.

Visit Maintenance Unlock Request Process cont'd

EVV Vendor and EVV PSO Approval and Denial

Once the EVV vendor or PSO receives the approved Visit Maintenance Unlock Request from the payer, the EVV vendor or EVV PSO must validate the information submitted.

Once the information is validated:

- The EVV vendor has 10 business days from receipt of the approved Visit Maintenance Unlock Request to complete visit maintenance or schedule a meeting with the program provider, FMSA or CDS employer to complete visit maintenance.
- The PSO must complete visit maintenance within 20 business days from receipt of the approved Visit Maintenance Unlock Request.

Visit Maintenance Unlock Request Process cont'd

If the information submitted by the program provider, FMSA or CDS employer is incorrect, invalid or missing data elements, the EVV vendor or PSO will:

- Not unlock EVV visit transaction(s) for visit maintenance.
- Return the Visit Maintenance Unlock Request to the program provider, FMSA or CDS employer.
- Notify the payer, program provider, FMSA or CDS employer of the reason the EVV visit transaction(s) cannot be unlocked for visit maintenance.

EVV vendors and payers cannot provide specific information about what data elements should be updated. The EVV vendor can direct the program provider, FMSA or CDS employer to the visit dates and members that are approved within the Visit Maintenance Unlock Request and provide education about the EVV system.

Once the information is corrected, the program provider, FMSA or CDS employer must submit a new Visit Maintenance Unlock Request to the payer.

Visit Maintenance and Billing EVV Claims

A program provider, FMSA and CDS employer must ensure all required data elements are correct and visit maintenance is complete before the program provider or FMSA submit an EVV claim to the appropriate claims management system.

If the program provider, FMSA or CDS employer needs to complete visit maintenance on an accepted EVV visit transaction that has already been billed, the program provider or FMSA must:

- Complete visit maintenance on the EVV visit transaction(s).
- Ensure the EVV Aggregator accepts the corrected EVV visit transaction.
- Resubmit the EVV claim per the payer's corrected claim process (e.g. negative bill the original claim and resubmit a corrected claim).

The EVV Visit Maintenance Unlock Request does not override the timely filing deadline for submission of a new or corrected claim. If an exception to the timely filing deadline is needed, program providers or FMSAs must follow the process of their payer.

Last Visit Maintenance Date

The Last Visit Maintenance Date field on the EVV visit transaction identifies the last date visit maintenance was completed. Payers may review the Last Visit Maintenance Date on the EVV visit transaction and the date and time TMHP received the associated EVV claim.

If the Last Visit Maintenance Date is after the EVV claim receipt date, the EVV claim is subject to recoupment. To avoid recoupment, program providers and FMSAs must submit an adjusted claim if visit maintenance is completed after initial claim submission.

The EVV system will update the Last Visit Maintenance Date when any of the following fields are updated:

- API/NPI
- Contract number
- Member Medicaid ID
- Service group
- Service code
- HCPCS code
- Modifier
- Bill hours
- Units
- Adding a Reason Code number
- Adding a Reason Code description
- Entering Reason Code free text

The program provider or FMSA may review the Last Visit Maintenance Date on the EVV Visit Log Report and the EVV visit detail screen located in the EVV Portal.

EVV Reason Code

Reason Code Number(s) represent the overall issue for the need to complete visit maintenance on an EVV visit transaction. Reason Code Description(s) provide more detail about why visit maintenance was completed.

Program providers, FMSAs or CDS employers must select the most appropriate Reason Code Number(s), Reason Code Description(s) and must enter any required free text when completing visit maintenance in the EVV system.

If an EVV visit transaction is missing a clock in or clock out, program providers, FMSAs or CDS employers must use Reason Code Number 900 Non-Preferred, the appropriate Reason Code Description(s), and any other applicable EVV reason code.

Program providers, FMSAs and CDS employers can use multiple Reason Code Numbers and Reason Code Descriptions to clarify more than one exception when completing visit maintenance on a single visit.

HHSC EVV Reason Codes- Effective Jan. 1, 2021

Program providers, Financial Management Services Agencies (FMSAs) and consumer directed services (CDS) employers must select the most appropriate EVV Reason Code Number(s), EVV Reason Code Description option (e.g., A, B, C, etc.), and enter any required free text when completing visit maintenance in the EVV system. All EVV Reason Code Numbers, except EVV Reason Code Number 900, are preferred EVV Reason Code Numbers.

Reason Code	Number	Reason Code Description
Overnight Visit (If applicable)	000	This EVV Reason Code Number is a system-generated reason code used by the EVV system when the EVV system auto-generates a clock out at 11:59 p.m. and a clock in at 12:00 a.m. for overnight visits. This EVV Reason Code Number is not available for program provider, FMSA or CDS employer use.
Service Variation	100	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when service variations occur.
		A - Staff hours worked differ from schedule
		B - Downward adjustment of pay hours
		C - Authorized services provided outside of home
		D - Fill-in for regular attendant
		E - Member agreed or requested staff not work
		F - Attendant failed to show up for work
		G - Confirm visits with no schedule
		H - Overlap visits
		I - Split schedules
		J - In-home respite: used when an in-home respite visit occurs and there is no schedule in the EVV system
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.

HHSC EVV Reason Codes- Effective Jan. 1, 2021

Reason Code	Number	Reason Code Description
Disaster	130	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when all or part of the scheduled visit could not be delivered due to a natural disaster.
		A - Flood
		B - Hurricane
		C - Ice/snowstorm
		D - Tornado
		E - Wildfire
		F - Public Health Disaster
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.
Emergency	131	The program provider, FMSA or CDS employer will select this reason code when all or part of the scheduled visit could not be delivered due to an emergency with the member. Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system and describe the nature of the emergency.
Alternative Device	200	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when an assigned alternative device could not be used to clock in and/or clock out.
		A - Alt device ordered
		B - Alt device pending placement
		C - Alt device missing
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.
Mobile Device	201	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when an assigned mobile device could not be used to clock in and/or clock out.
		A - Mobile device ordered
		B - Mobile device pending placement
		C - Mobile device missing

HHSC EVV Reason Codes- Effective Jan. 1, 2021

Reason Code	Number	Reason Code Description
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.
Technical Issues	300	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when technical issues prevented staff from clocking in and/or clocking out of the EVV system.
		A – Phone lines not working
		B – Malfunctioning alternative device
		C – Incorrect alternative device value
		D – Incorrect employee ID entered
		E – Incorrect member EVV ID entered
		F – Malfunctioning mobile device/application
		G – Multiple calls for one visit
		H – Reversal of call in/out time
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.
Landline Not Accessible	400	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when the member's home phone landline was not accessible and prevented staff from clocking in and/or clocking out of the EVV system.
		A - Member does not have home phone
		B - Member phone unavailable
		C - Member refused staff use of phone
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.
Service Suspension	500	The program provider, FMSA or CDS employer will select this EVV Reason Code Number when the member's services are suspended due to a lapse in eligibility.

HHSC EVV Reason Codes- Effective Jan. 1, 2021

Reason Code	Number	Reason Code Description
Other	600	The program provider, FMSA or CDS employer will select this EVV Reason Code Number when an exception cannot be addressed using any other EVV Reason Code Number and EVV Reason Code Description. Free text is required: The program provider, FMSA or CDS employer must explain the reason for using this code and provide any missing clock in or clock out time not electronically captured by the EVV system.
Non-Preferred	900	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when staff have failed to clock in and/or clock out of the EVV system.
		A – Failure to call in
		B – Failure to call out
		C – Failure to call in and out
		D – Wrong phone number
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.

EVV Provider Compliance

Electronic Visit Verification (EVV) Compliance Oversight Reviews

State mandated EVV Compliance Oversight reviews and monitors program providers use of an EVV vendor to electronically document authorized service delivery visits. Aetna Better Health of TX Compliance department is required to periodically monitor and report EVV provider usage and appropriate use of reason codes.

- Aetna program providers will be reviewed on a regular basis to ensure they are following EVV policies in the following areas:
  - **EVV Usage**
    - Program providers will be reviewed for manually entered visits and rejected visit transactions. Meet the Minimum EVV Usage Score of 80% in a state fiscal quarter.
  - **EVV Reason Codes and Required Free Text**
  - Program providers will be reviewed for use of most appropriate reason codes and required free text.
  - **EVV Landline Reviews**
    - Program providers will be reviewed for landline numbers used to clock in and out.

EVV Provider Compliance

- The EVV Provider Compliance review schedule will align with the state's fiscal quarters. The new EVV Compliance review quarters are:
  - Quarter 1 = September/October/November
  - Quarter 2 = December/January/February
  - Quarter 3 = March/April/May
  - Quarter 4 = June/July/August

EVV Compliance Requirements cont'd

EVV USAGE REVIEWS (NEW)

Effective for visits on or after **September 1, 2019**, the EVV Usage Review will monitor:

- Graphical User Interface (GUI) EVV visit transactions; and
- Rejected EVV visit transactions.
  - A **GUI visit transaction** is a manually entered visit into the EVV system.
  - A **Rejected EVV visit transaction** is an EVV visit transaction submitted to the EVV Aggregator from an EVV Vendor that is not accepted because it does not pass visit validation edits.

Compliance Standard

All program providers must achieve and maintain a minimum EVV Usage score of eighty percent (80%) per quarter; unless otherwise notified by HHSC. This score applies for both HHSC Fee for Service and MCOs programs.

Grace Period

Program providers currently required to use EVV will receive a grace period for visits between September 1, 2019 through August 31, 2020.

- The grace period is a time for program providers to:
  - Train/re-train their staff on how to use the EVV system.
  - Pull the *EVV Usage Report* and become acclimated to the data.
-

What is the EVV Aggregator & its Purpose?

The EVV Aggregator is a centralized database that collects, validates, and stores statewide EVV visit data transmitted by an EVV system effective Sept.1, 2019.

The Texas Medicaid & Healthcare Partnership (TMHP), the Texas Medicaid claims administrator, is responsible for operating and maintaining the EVV Aggregator and EVV Portal.

The EVV Aggregator:

- Provides validated provider contract(s) or enrollment data to the EVV vendors.
- Accepts or rejects confirmed EVV visit transactions using standardized validation edits and returns these results to the EVV vendors.
- Stores all accepted and rejected EVV visit transactions.
- Matches EVV claim line items to accepted EVV visit transactions in the EVV Aggregator and sends matching results to Aetna and other payers for EVV claims processing.

How will this improve EVV?

The EVV Aggregator improves data quality with standardized validations against state data. It reduces the need for manual entry, which then decreases data element errors on visit transactions.

- Consistent visit data validation will be performed on all EVV visit transactions.

- EVV claims matching is standardized. The same critical data elements will be used for EVV claims matching for all EVV payers.

- The EVV Aggregator stores accepted and rejected EVV visit transactions from the EVV vendors and allows review of top rejection issues and percent of rejections by EVV vendor and provider.

What is the EVV Portal?

The EVV Portal is an online system that allows users to perform searches and view reports associated with the EVV visit data in the EVV Aggregator.

Program providers, FMSAs and Aetna health plan are able to search, view, print, and export:

- EVV visit data (accepted and rejected EVV visit transactions).
- EVV visit transaction to EVV claim line items matching results.
- Provider identification data.

Note: CDS employers will not use the EVV Portal. However, they will have access to visit logs and related reports in the EVV vendor system.

Users can:

- View EVV visit transactions ready for billing.
- Access standard EVV reports and run queries on EVV visit data.
- Check the status and identify reasons for rejection of submitted EVV visit transactions.

What is the EVV Portal cont'd

Check the EVV Portal before submitting EVV claims.

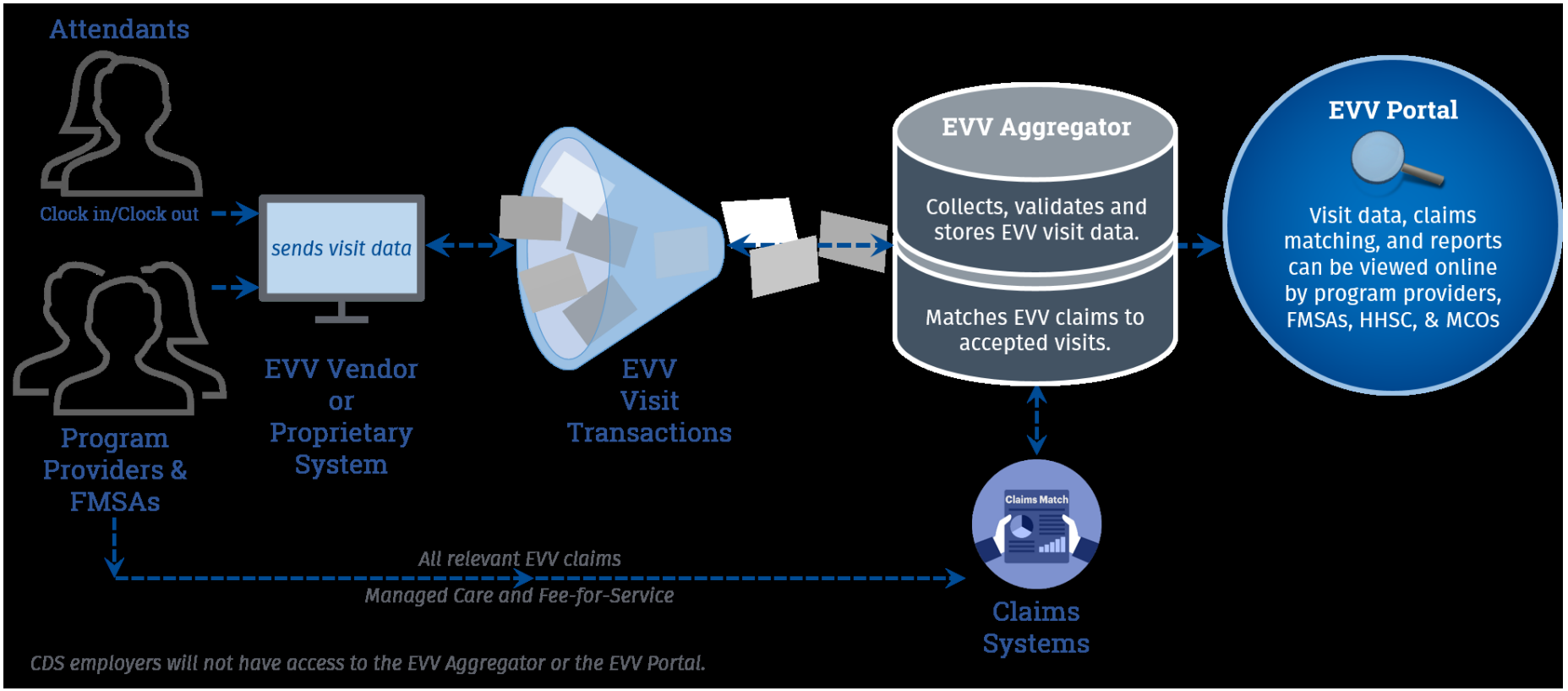
EVV Portal users can view accepted EVV visit transactions that are ready for billing and ensure the EVV visit transactions were accepted prior to submitting EVV claim line items.

When TMHP receives an EVV claim, the EVV claim line items will be matched against the accepted EVV visit transactions.

EVV Portal users can use the "Accepted Visit Search," "History/Rejected Visit Search," and "EVV Claim to Visit Search" tabs to select specific criteria to run searches for:

- Accepted EVV visit transactions.
- Rejected EVV visit transactions.
- History of updates made to EVV visit transactions.
- EVV claims to EVV visit transaction match results.

EVV Systems Overview of the EVV Aggregator



EVV Claims Submission

HHSC implemented a new claims matching process **effective Sept. 1, 2019**, for current program providers required to use EVV.

➢ This is for visits with Date of Service on or after Sept. 1, 2019

Effective Jan. 1, 2021, the claims matching process will begin for new program providers and FMSAs required to use EVV. This is for visits with Date of Service on or after Jan. 1, 2021

Claims for Aetna Better Health of TX EVV services will be submitted to **TMHP** through TexMedConnect or through Electronic Data Interchange (EDI) using a Compass 21 (C21) Submitter ID.

Program providers and FMSAs that need help setting up C21 or CMS Submitter IDs should contact the TMHP EDI Help Desk at 1-888-863-3638, Option 4

- When an EVV claim is received by TMHP, the EVV claim line items will be matched against the accepted EVV visit transactions, previously sent by the EVV vendor systems.
- Once the matching process has been performed, all EVV claims will be forwarded to Aetna for normal review and consideration for final EVV claims processing.

Please note!

EVV claim line items without matching EVV visit transactions are denied upfront (prepayment review) by Aetna Better Health.

EVV Claims Submission cont'd

EVV claims with dates of service on or after Sept. 1, 2019 submitted directly to Aetna Better Health of Texas will be rejected or denied. Program providers will receive a response from the health plan informing them to submit EVV claims to TMHP.

Aetna Program providers and FMSAs can submit EVV claims with a range of service dates (span dates), or by single date of service.

If a Provider submits span dates, please ensure that:

- Each date has one or more matching EVV visit transactions.
- The total units on the EVV claim must match the combined total units of the matched EVV visit transactions.

EVV claims with date spans that start prior to Sept. 1, 2019 will be rejected by TMHP.

- Aetna Program providers and FMSAs can view accepted EVV visits in the EVV Portal before submitting their EVV claims.
- If a Provider submits a span claim that includes Dates of Service before Sept. 1, 2019 to TMHP and after (or on) Sept. 1, 2019 to Aetna, the claim lines with Dates of Service prior to Sept. 1, 2019 will be denied. Claims prior to Dates of Service before 9/1/19, should be submitted to Aetna Better Health directly.
- Aetna Program providers and FMSAs should always check the EVV Portal to ensure the EVV visit has been accepted by the EVV Aggregator before submitting the associated claim.

EVV Claims Matching for HCS and TxHmL Will Begin for Dates of Service Starting May 1, 2023

- https://www.hhs.texas.gov/provider-news/2023/02/07/evv-claims-matching-hcs-txhml-will-begin-dates-service-starting-may-1-2023

- HHSC has extended the start date when Electronic Visit Verification claims for Home and Community-based Services and Texas Home Living will deny for no matching EVV visit. EVV claims matching will begin with dates of service May 1, 2023, and after. Program providers, financial management services agencies and Consumer Directed Services employers must continue to use EVV during this time.
- The extension provides HCS and TxHmL program providers and financial management services agencies more time to improve claims matching. This includes more outreach and training from the Texas Medicaid and Healthcare Partnership. Training webinars will be announced at a future date.
- The EVV Personal Care Services Bill Codes table reflects the updated billing details. The table is in Excel and PDF formats on the EVV web page.
- For more information about billing updates for HCS and TxHmL, including resources to help avoid future payment denials or recoupments, reference the notice, EVV Billing Updates for HCS and TxHmL (PDF).
- We will continue to post related updates and reminders. If you have not signed up to receive EVV notices by email, sign up for GovDelivery.
- Email EVV Operations for questions.

Claims Filing Instruction

Effective 7/1/2019, Aetna Better of Health of Texas will require rendering and billing taxonomies on the claims submitted electronically or via paper.

Required Data Element	Paper CMS 1500	Electronic – CMS 1500
Billing Provider Taxonomy	Box 33b with qualifier ZZ	Loop ID – 2000A Segment – PRV03
Rendering Provider Taxonomy	Box 24j - shaded area with qualifier ZZ in 24i	Loop ID – 2310B Segment – PRV03 Loop ID – 2420A Segment – PRV03
Required Data Element	**CMS 1450 (UB-04)**	**Electronic – CMS 1450 (UB-04)**
Billing Provider Taxonomy	Box 81CC with qualifier B3	Loop ID – 2000A Segment – PRV03
Rendering Provider Taxonomy	Not Applicable (n/a)	Not Applicable (n/a)

If these data elements are missing or invalid, claim will be rejected with a remit message of:
N255 – if billing taxonomy is invalid or missing
N288 – if rendering taxonomy is invalid or missing

Claims Filing Instruction cont'd

- Provider taxonomy (rendering and billing) will be considered invalid if the submitted taxonomy is not one of the taxonomies with which the provider record is enrolled with Texas Medicaid & Healthcare partnership (TMHP). It is critical that the taxonomy code selected as the primary or secondary taxonomy code during a provider's enrollment with TMHP is included on all electronic and paper transactions.

Note that rejected claims do not count as clean claims; please ensure that claims are submitted within 95 days from the date of service.

- A clean claim must have all the necessary data for the claim processor to adjudicate and accurately report the claim. It must meet all the requirements for accurate and complete data as defined in the appropriate claim type encounter guides.
- For any questions, please reach out to Provider Relations at:

Medicaid STAR Kids Tarrant/Dallas: **1-844-787-5437**

Reminder

Providers must ensure that **all taxonomies used** to bill LTSS services are attested to their NPI through the Centers for Medicare & Medicaid Services National Plan and Provider Enumeration System (NPPES). Additionally, all NPI/taxonomy combinations currently used to bill Medicaid LTSS services must be enrolled through either the Texas Medicaid and Healthcare Partnership (TMHP) via the LTSS Provider Enrollment Process.

- ***The Texas Medicaid enrollment process is a separate and distinct process from contracting and credentialing with an Aetna Better Health of TX. Even if you are currently contracted and credentialed with our plan, your contract will become invalid if you have not completed the Medicaid enrollment process for all NPIs and taxonomies used to bill LTSS services and been approved by either HHSC or TMHP.***

Claims Submission Helpful Hints

The following scenarios impact claim payment delays and/or denials:

- Offices submit claims/bills with different NPI/TPI numbers vs. what is listed on the state's master file causing claim denials.
- Attestation is not updated or completed (please contact TMHP if you receive any correspondence and remember to act immediately).
- Diagnosis/procedure codes do not support modifiers billed-see your manual for additional guidance.
- Provider's address is listed incorrectly in our system resulting in payments being distributed to the incorrect address. Please send any address changes or demographic changes to: **ABHTXCredentialing@aetna.com**

EVV Claims Matching Process

The EVV Aggregator will match the EVV claim line item with the accepted EVV visit transactions using the following critical data elements:

- National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Date of service
- Medicaid ID
- Healthcare Common Procedure Coding System (HCPCS)
- Modifiers, if applicable
- Units

EVV claim line items that are not successfully matched with EVV visit transactions will be denied by Aetna Better Health of TX.

EVV Claim Match Result Codes

The following list of EVV claim match result codes will be used to inform program providers or FMSAs of matching results.

Program providers and FMSAs will be able to view matching results in the EVV Portal:

- EVV01- EVV Match
- EVV02- Medicaid ID Mismatch
- EVV03- Visit Date Mismatch
- EVV04- Provider Mismatch (National Provider Identifier (NPI) or Atypical Provider Identifier (API) Mismatch)
- EVV05- Service Mismatch (Healthcare Common Procedure Coding System (HCPCS)/Modifier Mismatch)
- EVV06- Units Mismatch
- EVV07- EVV Claims match not performed per State direction.
- EVV08 - EVV Claims match not performed due to a Natural Disaster.

Aetna EVV Updates as of 6/1/19

June Release by HHSC - EVV Transaction Edits

EVV visits with Dates of Service on or after 6/1/19 will be subject to new edits; existing TMHP validation edits will be applied for visits with Dates of Service prior to 6/1/19. Aetna Better Health of TX understands during this transition, we may see fewer accepted visits as providers work to correct rejected transactions.

- Aetna Better Health of TX has opted to receive TMHP EVV validation edit response files allowing EVV Transaction data to be more accurate due to vendor updates.

Please note: All EVV transactions with dates of service on or after 9/1/2019 will be validated by TMHP and subject to the new validation edits as part of the centralized matching process.

EVV Portal Effective 9/1/19 & EVV Reports

Program providers, FMSAs, Aetna Better Health of TX will have access to standard EVV reports in the EVV Portal for dates of service on or after September 1, 2019.

- EVV standard reports only include EVV visit transactions accepted by the EVV Aggregator and be considered the source of truth and used for contract monitoring, recoupments, and enforcement purposes.
  - Can be used to conduct contracting and billing audits.
  - EVV compliance monitoring.
  - Medicaid fraud investigations.
  - Texas Medicaid data analysis.
- Current program providers using the DataLogic vendor system will continue to pull EVV standard reports for dates of service prior to September 1, 2019, from DataLogic's Vesta EVV system or other HHSC approved EVV Vendor.
- The EVV Portal will only display visits with dates of service on or after September 1, 2019.

Please note!

CDS employers will pull CDS-specific reports from the EVV vendor system (not the EVV Portal).

EVV Portal Standard Reports

The EVV Portal will include the following standard reports available for access by Aetna Providers:

- EVV Visit Log
- Units of Service Summary (FFS only)
- EVV Usage Report
- EVV Reason Code Usage and Free Text

The list of HHSC approved EVV standard reports is subject to change. Providers may access HHSC's resource link on slide 71 for additional information and detail of the EVV Standard Reports that are available.

New EVV Validation Process by HHSC

EVV Visit Transaction Validation Enhancements affect program providers required to use EVV.

On June 1, 2019, the Health and Human Services Commission (HHSC) will implement a visit validation process to standardize and improve accuracy of EVV visits and reduce data corrections by program providers.

- The visit validation process will help program providers prepare for the new claims matching process that will begin Sept. 1, 2019, by ensuring visit data is complete, correct and accepted by the EVV Aggregator.

- EVV visit transactions with a date of service on or after June 1, 2019 with incomplete or incorrect visit data will be rejected at the EVV Aggregator. This process does impact Aetna STAR Kids Providers who submit EVV claims.

EVV Billing Recap & Best practices

- Aetna providers should use the period between June 1, 2019 and August 31, 2019 to clean up relevant data in the DataLogic EVV system
- Get prepared for the new claims matching process effective **Sept. 1, 2019**
- An accepted EVV visit transaction is required for the new claim matching process.
- Without an accepted EVV visit transaction in the EVV Aggregator, EVV claims will be denied
- EVV relevant claims are subject to the matching process to confirm that a service visit occurred prior to the payment of a claim.
- Both claims submitted with a single date of service and claims submitted with a span of service dates will be permitted.

Please Note!

Aetna Better Health of Texas will allow span dates for billing EVV services. If our Program providers submit span dates for billing EVV services, the following criteria must be met for the EVV matching process:

- Each date within the span of dates must have one or more associated EVV visit(s) and;
- The total units on the claim must match the combined total units of the matched EVV visits for the span dates.

EVV Billing Recap & Best practices cont'd

- If a date within the span does not have an associated EVV visit, the claim will deny for no EVV match.
- If the total units of the matched EVV visits for the date span does not match the units billed on the claim, the claim will deny.
- Claims submitted without a matching EVV visit transaction for the specified date(s) of service will be denied.
- Aetna Better Health of Texas, as a prepayment claims reviewer, does not pay EVV claims without any matching EVV transaction
- Become familiar with the EVV system and operations
- Set a date prior to the 60 day deadline to complete any required visit maintenance.

For additional details about this new process, please visit our website at: https://www.aetnabetterhealth.com/texas/providers/info/evv

Program providers and FMSA's may also access State mandated guidance regarding this new process at: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification/21st-century-cures-act

EVV Codes Billing Matrix – STAR Kids

LTSS Billing Matrix and Crosswalk

Appendix III, LTSS Billing Matrix and Crosswalk | Texas Health and Human Services –

https://www.hhs.texas.gov/handbooks/star-kids-handbook/appendix-iii-ltss-billing-matrix-crosswalk

Updates to the Bill Code Crosswalks for Individualized Skills and Socialization Services

Updates to the Bill Code Crosswalks for Individualized Skills and Socialization Services | TMHP

https://www.tmhp.com/news/2023-01-09-updates-bill-code-crosswalks-individualized-skills-and-socialization-services

Checking Claim Status

Our HIPAA compliant web portal is available 24-Hours a day. The portal supports the functions and access to information related to:

- Prior authorization submission and status
- Claim payment status
- Member eligibility status
- Referrals to other registered providers
- Member and provider education and outreach materials

If you're interested in using this secure online tool, you can register on our "For Providers" then "Portal" page at **aetnabetterhealth.com/texas**.

To register for the provider portal contact our Provider Services Department at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar) to sign up over the phone. Keep in mind that Internet access with a valid email is required for registration.

EVV Claims Denial

EVV claim line items will be denied if:

- Critical data elements do not match the EVV claim.
- The claim is not submitted according to our guidelines regarding span dates.
- A date within the span of dates does not have a matching EVV visit.
- The total units of the matched EVV visit for a date span doesn't match the units billed on the EVV claim.
- EVV claims can be denied for other valid reasons by Aetna (Example: Prior Authorization, timely filing or eligibility)

These changes will not affect the current formatting of your Explanation of Benefits

Claims Appeals- STAR & STAR Kids

Appeals: Can be submitted in writing or on-line

1. For Written submission:

- Appeals should be sent with the Appeal Form. Clearly defined requests will ensure that appeals are reviewed in the most appropriate way. Please include claim forms, EOB (or copy) , appropriate documentation and *specifically* indicate what services are being appealed.
- A revised Appeals/Reconsideration form is available on our website: https://www.aetnabetterhealth.com/texas
- Appeal requests must be received within 120 calendar days from the resolution date on the most recently reviewed claim's EOB.
- Appeal requests should be mailed to the following address:

Aetna Better Health

Appeals and Correspondence

PO Box 81040

5801 Postal Rd

Cleveland, OH 44181

Claims Appeals cont'd- STAR & STAR Kids

2. **For On-Line Appeal Submission:**
   - Log on to the Availity Provider Portal **https://apps.availity.com/availity/web/public.elegant.login**
   - Single and Bulk appeals can be submitted thru Availity

Claims Reconsiderations- STAR & STAR Kids

Reconsiderations:

Reconsiderations should be sent with *at least* the following info.:

1. Claim form for each reconsideration.
2. EOB (or copy) for each resubmitted claim, with indications of which claim is being resubmitted
3. Any information that was previously requested from the Health Plan.

Reconsiderations requests (other than Coordination of Benefits (COB) related resubmissions) must be received within 120 days of the resolution date on the original (clean) claim's EOB.

1. COB related resubmission:
   - Are identified as claims previously denied for other insurance information, or originally paid as primary without coordination of benefits.

Administrative Appeals

Provider agencies may contact Aetna Better Health for information about their administrative appeal processes.

Claims

- Provider agencies must ensure claims for services are supported by service delivery records that have been verified by the provider agency and fully documented in an EVV System that has been approved by HHSC.

- Claims are subject to denial or recoupment if they are submitted before all of the required visit maintenance has been completed in the EVV System and if the services are not supported by an EVV transaction.

- Claims that are not supported by the EVV system will be subject to denial or recoupment.

Please Note!

It's the Provider agency's responsibility to ensure all required data elements and visit maintenance is completed prior to billing the claim to the health plan.

‘Standard’ Aetna Better Health Claim Submission

Reminder!

NON-EVV related claims submission processes are not changing and remain the same.

Aetna Better Health encourages participating providers to electronically submit claims through Change Healthcare (formerly Emdeon). You can submit claims by visiting Change Healthcare at https://www.changehealthcare.com/ . Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with Change Healthcare.

- Please use the following Payer ID when submitting claims to Aetna Better Health:
- Change Healthcare (formerly Emdeon) – Use Payer ID 38692

- If your electronic billing vendor is unable to convert to 38692, you may have them continue to use the Aetna commercial Payer ID 60054. If using this payer ID, we recommend that you use “MC” prior to the member number to make sure the claims are processed correctly.

EVV Visit Maintenance Reconsideration Process

EVV (Electronic Visit Verification)

Purpose: If a provider agency needs to access and conduct visit maintenance for claims reconsideration, provider agencies may submit a request to Aetna regarding the affected individual or member.

The EVV Reconsideration process applies to State approved data element changes to EVV visit(s) outside of the 60 days after the Date of Service. It is at Aetna's discretion to approve or deny the request. All requests are reviewed on a case-by-case basis.

Providers normally have 60 days from the date of the visit(s) to perform visit maintenance in the EVV vendor system. If a provider did not make the correction to the visit(s) within the allotted 60 days, a **Visit Maintenance Unlock Request Form** is used to request approval to open visit maintenance from Aetna Better Health of Texas for the visit(s) the provider wishes to correct.

EVV Visit Maintenance Reconsideration Process cont'd

Instructions for requesting the EVV Visit Maintenance Unlock for Reconsideration are below.

The Requestor: Must submit a request in writing **securely** via email to the Aetna Better Health of Texas at: EVVMailbox@Aetna.com

The request must include all required information and supporting documentation listed below. If a request is not sent **securely** or if any required information is missing, the request will not be considered.

Required Information:

- Provider Name
- Payor's Name
- EVV Vendor Name
- HHSC (DADS) Contract Number
- National Provider Identification Number (NPI)
- Tax Identification Number (TIN)
- Individual/member(s) Name
- Individual/member(s) Medicaid ID
- Date access is needed and requested timeframe for access
- What fields are needing changed (i.e. HCPCs, modifiers)

The Requestor should include an explanation of why access to visit maintenance past 60 days is needed. Please include any supporting documentation.

EVV Visit Maintenance Reconsideration cont'd

Timeliness Acknowledgement: Upon receiving the EVV Visit Maintenance Reconsideration request via secure email, Aetna will acknowledge receipt of the request within 48 hours. We will email the State approved **EVV Unlock Visit Maintenance** Excel spreadsheet form to the Provider agency to complete fully. When the EVV Unlock Visit Maintenance form is received by the health plan, please allow 5-7 business days for review and further instruction.

- Aetna will review the case and determine if we are going to unlock visit maintenance. If the request is **approved**, Aetna will reach out to your EVV Vendor and ask to unlock VM setting a specific time limit of how long VM will remain open to make corrections.
- Aetna will generate an approval notification email to alert you that a response should be forwarded by the EVV Vendor regarding the request.
- Your EVV Vendor should outreach to you within 7 calendar days allowing you to conduct visit maintenance on State approved data elements for the time frame that was decided by Aetna.
- Once EVV Visit Maintenance has been completed and an updated transaction file has been received from the EVV Vendor, a Reconsideration claim may be submitted to the EVV Aggregator for claims matching
- If your EVV Unlock Visit Maintenance request is **not approved** after review, Aetna will send an email notification to advise why the request could not be approved.

21st Century Cures Act and EVV News!

HHSC Informational Letter issued May 13, 2019

Information Letter No. 19-10–The 21st Century Cures Act and the Required use of the Electronic Visit Verification System

The information contained in this letter is applicable to program provider agencies, financial management services agencies and employers directing services through the Consumer Directed Services (CDS) option.

The 21st Century Cures Act, a federal requirement, mandates all states use Electronic Visit Verification (EVV) for all Medicaid Personal Care Services (PCS) and home health services or risk a loss of Federal Financial Participation (FFP), also referred to as Medicaid matching dollars. The implementation of EVV for PCS is required by January 1, 2021, and January 1, 2023, for home health services.

Prior to the Cures Act, Texas instituted EVV in certain programs which included state plan PCS programs like Primary Home Care and Community Attendant Services, as well as Community Living Assistance and Support Services (CLASS) waiver in-home respite and residential habilitation services.

With the passage of the Cures Act, Home and Community-based Services (HCS), Texas Home Living (TxHmL), and Deaf-Blind with Multiple Disabilities (DBMD) program providers will also be required to use EVV. The Cures Act also extends EVV to the CDS option. Historically under state rules, CDS employers could choose to use EVV, but were not mandated to do so.

21st Century Cures Act & CDS Employers

The following HHSC programs and services are not currently required to use EVV and thus will be impacted by the expansion of EVV. The first phase of the EVV expansion related to PCS will be implemented by January 1, 2021 (need to revise table date)

Program	Services and Service Delivery Options Requiring Electronic Visit Verification (January 1, 2020)
1915(c) Deaf-Blind with Multiple Disabilities Waiver	Community First Choice (CFC) Personal Assistance Services (PAS)/Habilitation (HAB) and In-Home Respite (Agency and CDS)
1915(c) Home and Community-based Services Waiver	CFC PAS/HAB, In-Home Respite, and Day Habilitation - provided in the home (Agency and CDS)
1915(c) Texas Home Living Waiver	CFC PAS/HAB, In-Home Respite, and Day Habilitation - provided in the home (Agency and CDS)
1915(c) Youth Empowerment Services Waiver	In-Home Respite (Agency)[2]
1915(i) Home and Community Based Services (HCBS) Adult Mental Health	Supported Home Living-Habilitative Support and In-Home Respite (Agency)[2]

21st Century Cures Act & CDS Employers cont'd

(need to revise table date)

Program	Services and Service Delivery Options Requiring Electronic Visit Verification (January 1, 2020)
1915(k) Community First Choice (including STAR Members who receive these services through the traditional Medicaid model)	CFC PAS and CFC HAB (Agency, CDS and the Service Responsibility Option (SRO))
Personal Care Services provided under the Texas Health Steps Comprehensive Care Program (including STAR members who receive these services through traditional Medicaid model)	Personal Care Services (Agency, CDS, and SRO)
STAR Health - MDCP Covered Services	In-Home Respite and Flexible Family Supports (Agency, CDS, and SRO)

21st Century Cures Act and CDS Employers cont'd

(need to revise table date)

The following HHSC programs and services are currently required to use EVV; however, as of January 1, 2020, individuals using the SRO/CDS option must use EVV.

Programs and Services Currently Required to Use EVV		Services and Service Delivery Options Requiring EVV (January 1, 2020)
1915(c) Community Living Assistance and Support Services waiver	CFC PAS/HAB and In-Home Respite (Agency)	CFC PAS/HAB and In-Home Respite (CDS)
Community Attendant Services	PAS (Agency)	PAS (CDS and SRO)
Family Care	PAS (Agency)	PAS (CDS)
Primary Home Care	PAS (Agency)	PAS (CDS and SRO)
STAR Health	CFC PAS, CFC HAB and Personal Care Services (Agency)	CFC PAS, CFC HAB and Personal Care Services (CDS and SRO)

21st Century Cures Act & CDS Employers cont'd

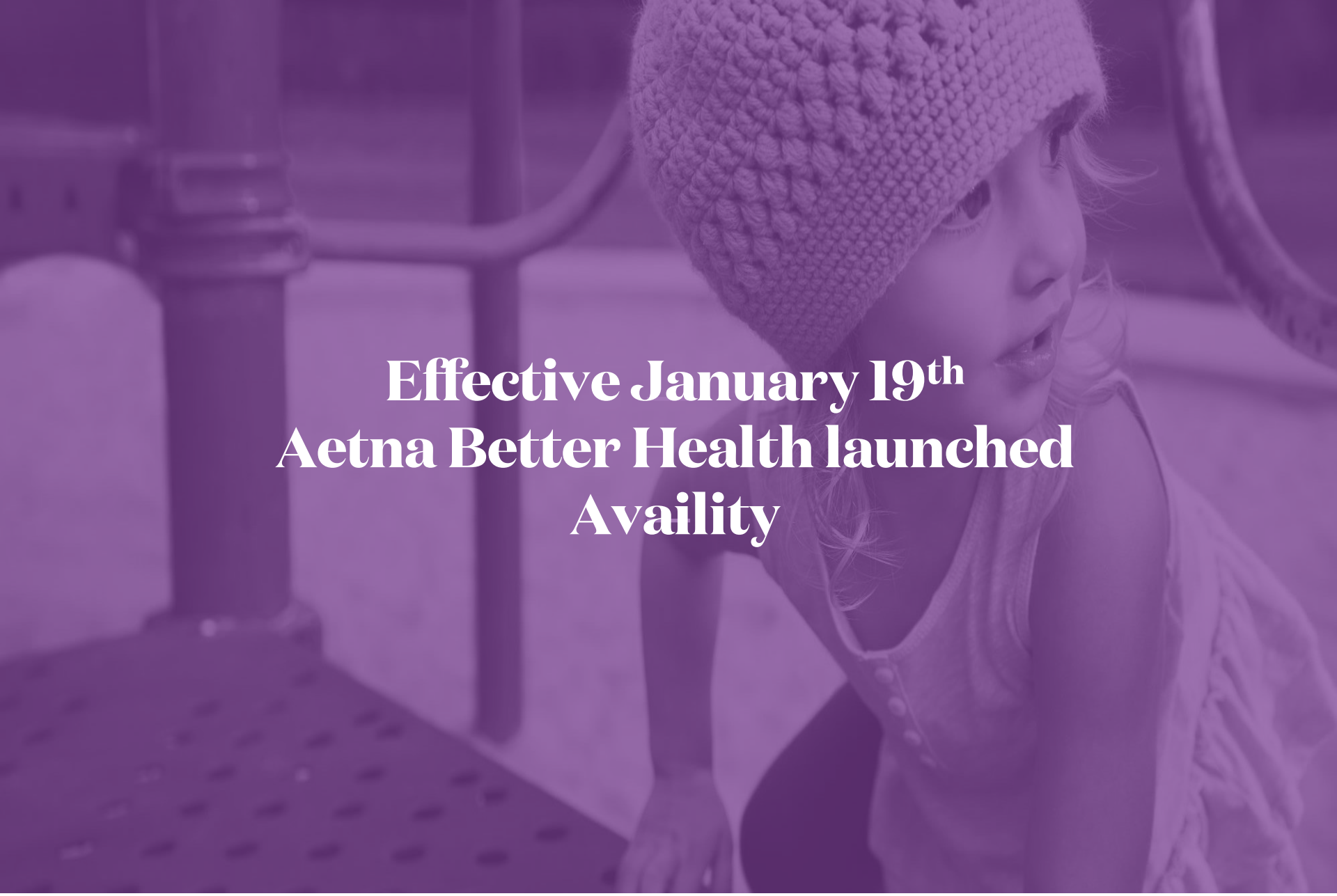
STAR Kids	CFC PAS, CFC HAB and Personal Care Services (Agency)	CFC PAS, CFC HAB and Personal Care Services (CDS and SRO)
STAR Kids - MDCP Covered Services	In-Home Respite and Flexible Family Supports (Agency)	In-Home Respite and Flexible Family Supports (CDS and SRO)
STAR+PLUS	CFC PAS, CFC HAB, and Personal Assistance Services (Agency)	CFC PAS, CFC HAB, and Personal Assistance Services (CDS and SRO)
STAR+PLUS Home and Community Based Services	Personal Assistance Services, In-Home Respite, and Protective Supervision (Agency)	Personal Assistance Services, In-Home Respite, and Protective Supervision (CDS and SRO)

Electronic Visit Verification – Contact Information

Questions regarding…	Contact…
• EVV Policies, processes & procedures • Claims inquiries, questions or rework • EVV Compliance monitoring & findings • EVV Unlock requests • Provider training & education	**Aetna Better Health of Texas** EVVMailbox@Aetna.com 1-844 STRKIDS (1-844-787-5437)

• EVV Aggregator
• EVV Portal
• EVV Training on the Following:
  ○ EVV Aggregator
  ○ EVV Portal
  ○ EVV Reports in the EVV Portal
  ○ EVV Claims Submission Process
• EVV Vendor Complaints
	TMHP EVV Mailbox: EVV@tmhp.com

TexMedConnect Account Setup • Creation or Modification of Submitter IDs • Submitting Claims for EVV Using TexMedConnect • Submitting Claims for EVV Using Electronic Data Interchange (EDI) • File Submission Errors • PIMS Assistance • Claim Rejections (excluding Long-Term Care [LTC] claim rejections with error code F, RJ, and/or AC) • Form Processing (i.e. EDI Agreement, TPA, and TPAEF)	**TMHP EDI Helpdesk:** P: 1-888-863-3638, Option 4



Effective January 19th Aetna Better Health launched Availity

HEALTH OF TEXAS

Availity Provider Portal

- **https://apps.availity.com/availity/web/public.elegant.login** or call **1-800-282-4548**
- We will offer dedicated Availity support for all providers who register for training. Providers will contact our Availity customer service line for assistance. Availity offers free on-demand and live training in the **Availity Learning Center** (ALC). Log in and select Help & Training > Get Trained to search the ALC catalog.
- For assistance with training questions/issues call **1-800-282-4548** between the hours of 8 AM and 8 PM ET, Monday through Friday.

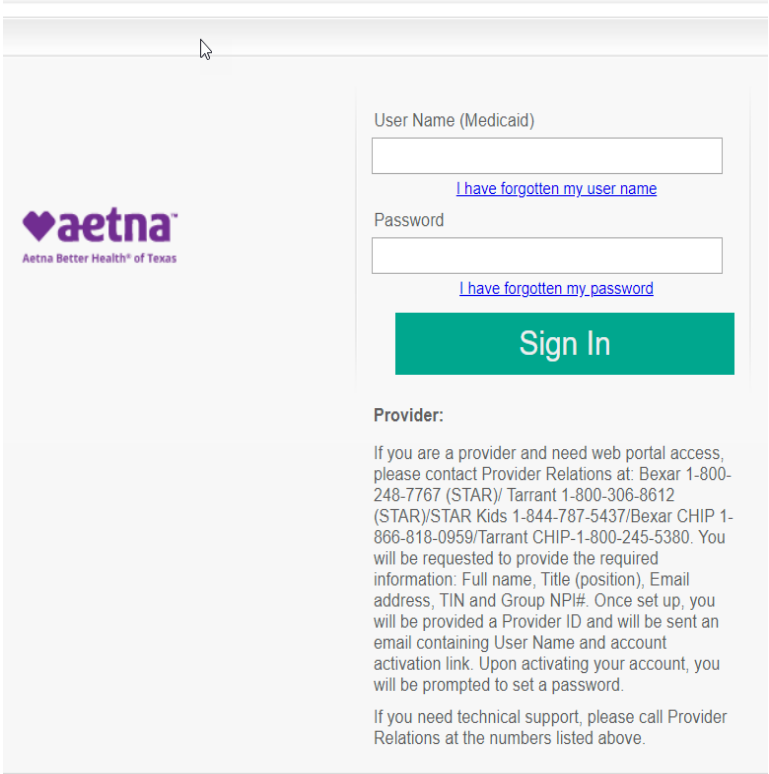
Registration for the Provider Web Portal

HEALTH OF TEXAS

Requires Unique Logon And Password

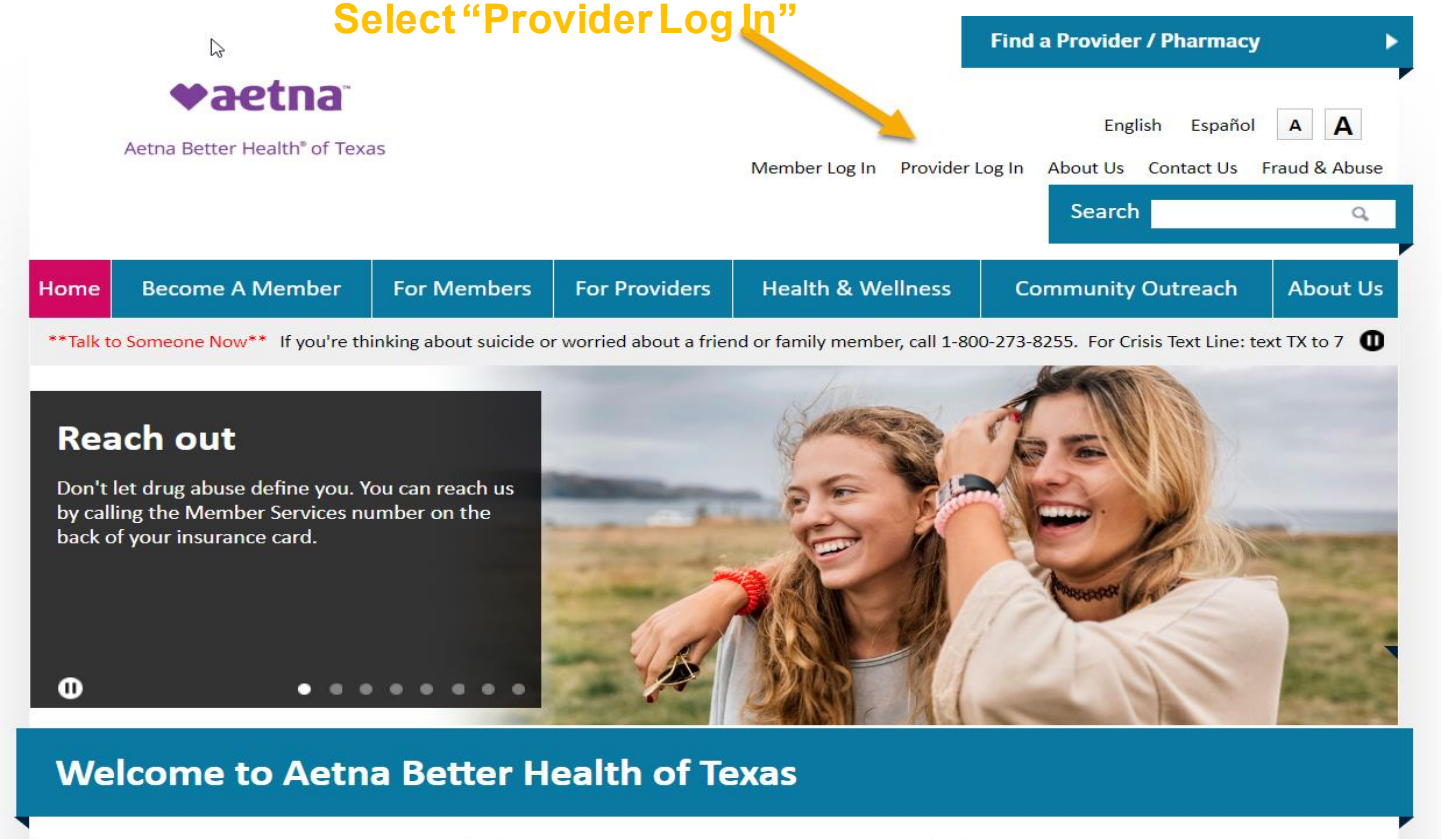
STEPS FOR INITIAL ACCOUNT SET UP

- Call: Bexar 1-800-248-7767 (STAR)/ Tarrant 1-800-306-8612 (STAR)/STAR Kids 1-844-787-5437/Bexar CHIP 1-866-818-0959/Tarrant CHIP-1-800-245-5380.
- Information needed to register:
  - Full name, Title (position)
  - Email Address
  - TIN
  - Group NPI
- Email will be sent containing username and activation link to enable first log in
- Upon activating your account, you will be prompted to set a password
- URL: https://medicaid.aetna.com/MWP/login.fcc?TYPE=

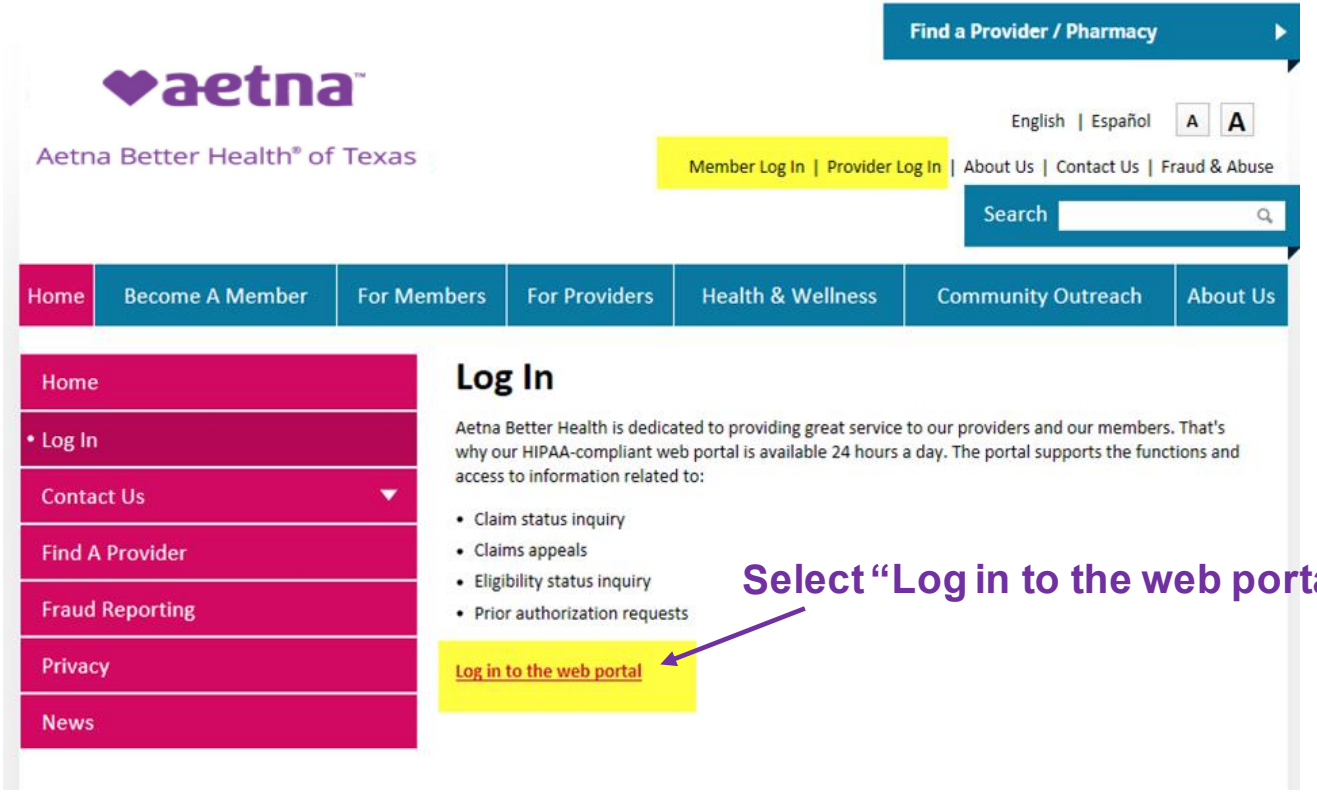


Aetna Better Health of Texas
Medicaid Portal – Website Links

Select "Provider Log In"



Aetna Better Health
Medicaid Portal – Website Links



Select "Log in to the web portal"

Provider Portal Home Page

Member Eligibility Verification

- Use the Aetna website at www.aetnabetterhealth.com/texas

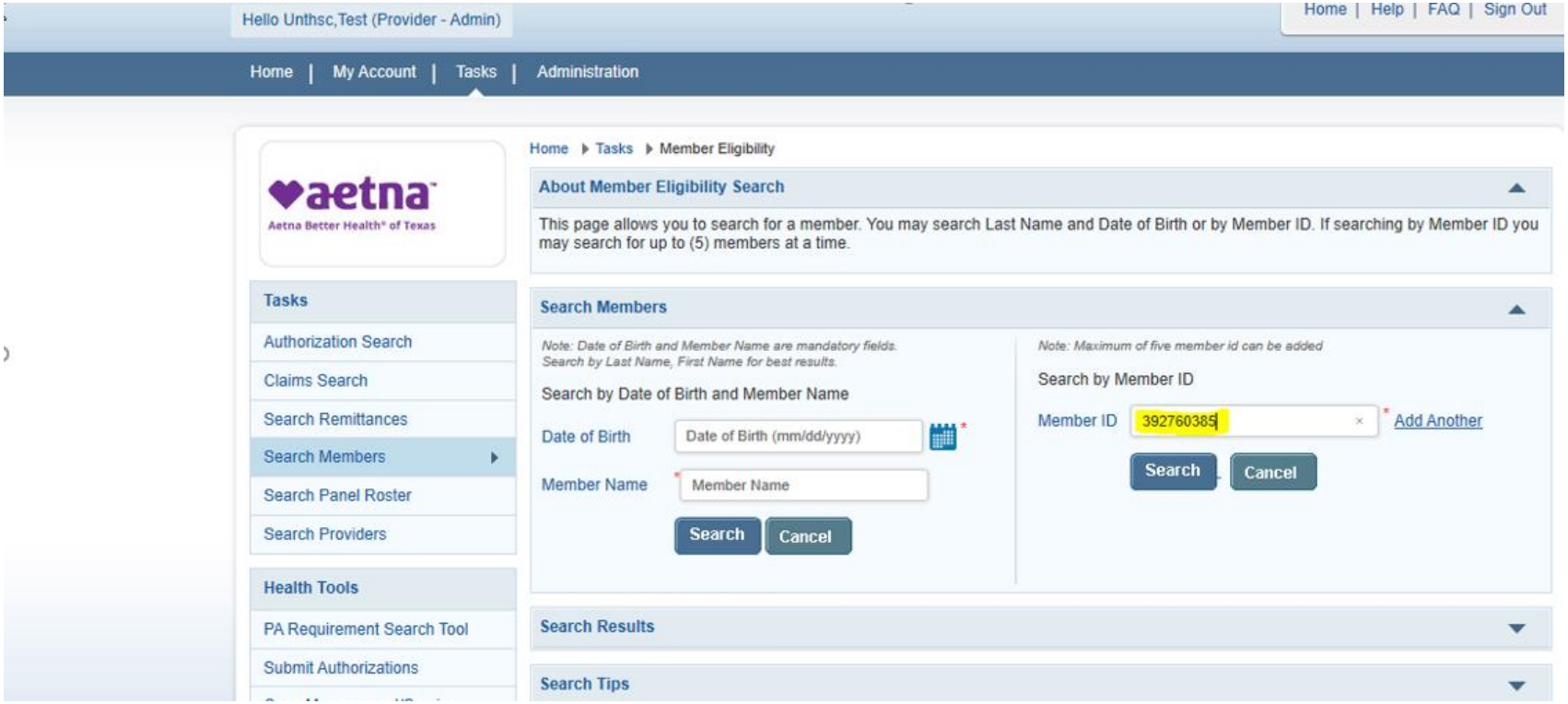
- Aetna Better Health Member Services

Service Area	STAR	CHIP
Bexar	**1-800-248-7767**	**1-866-818-0959**
Tarrant – STAR **Tarrant – STAR Kids** **Dallas – STAR Kids**	**1-800-306-8612** **1-844-STRKIDS** **(844-787-5437)** **1-XXX-XXX-XXXX**	**1-800-245-5380**

*These numbers provide access to a **Behavioral Health Hotline** that operates **24 hours** a day / **7 days** a week.*

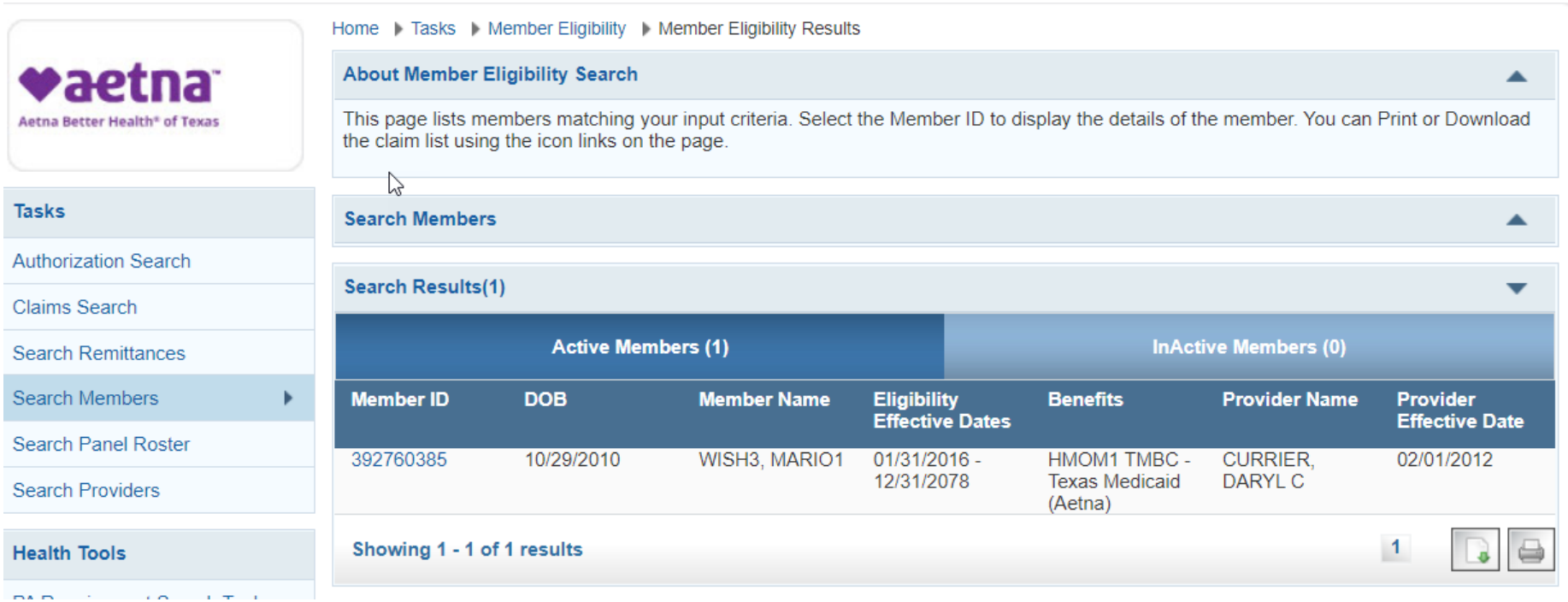
Tasks on the Provider Portal Home Page

Member Search



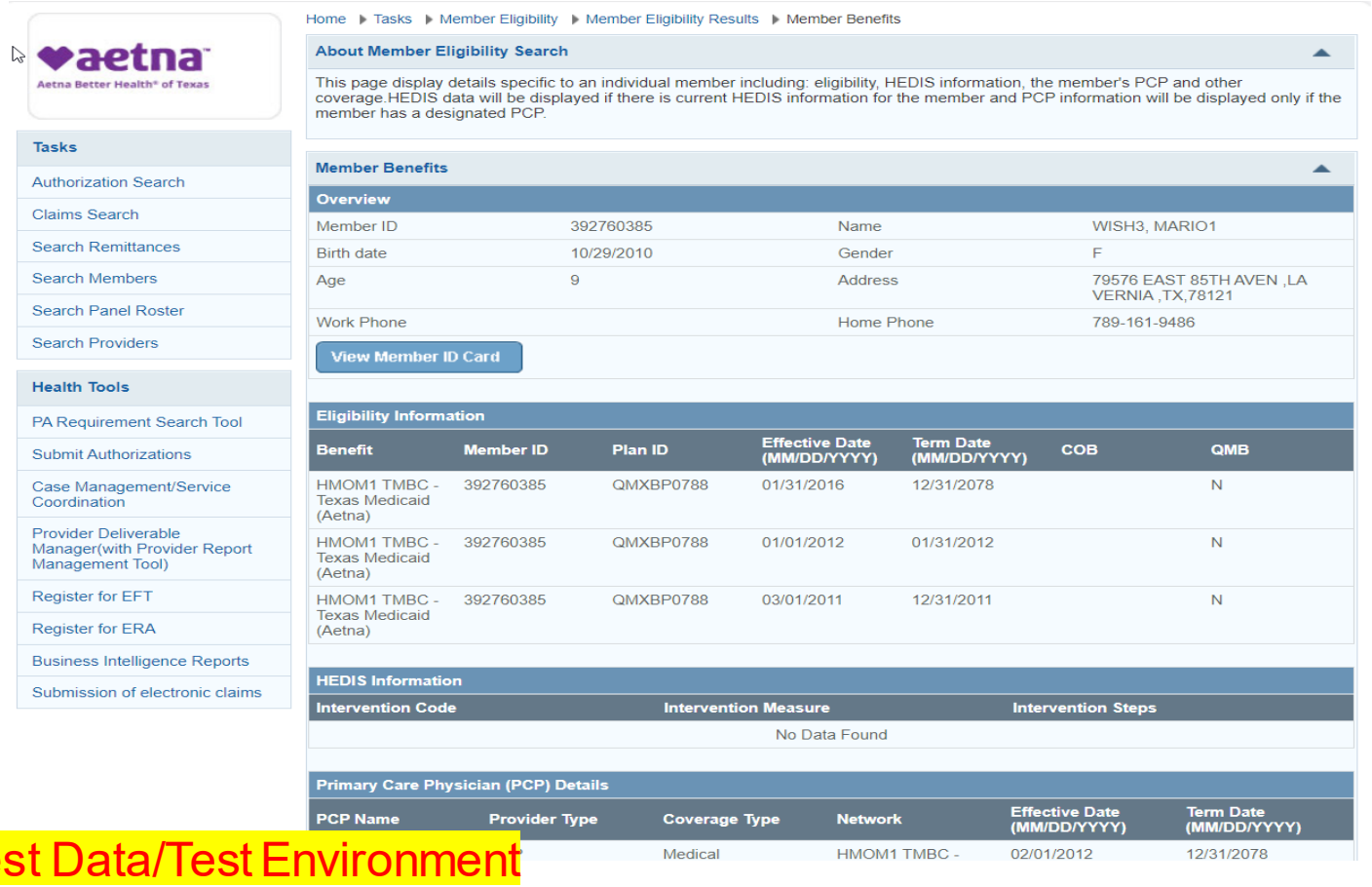
Test Data/Test Environment

Eligibility Search Results



Test Data/Test Environment

Eligibility Search Results cont'd

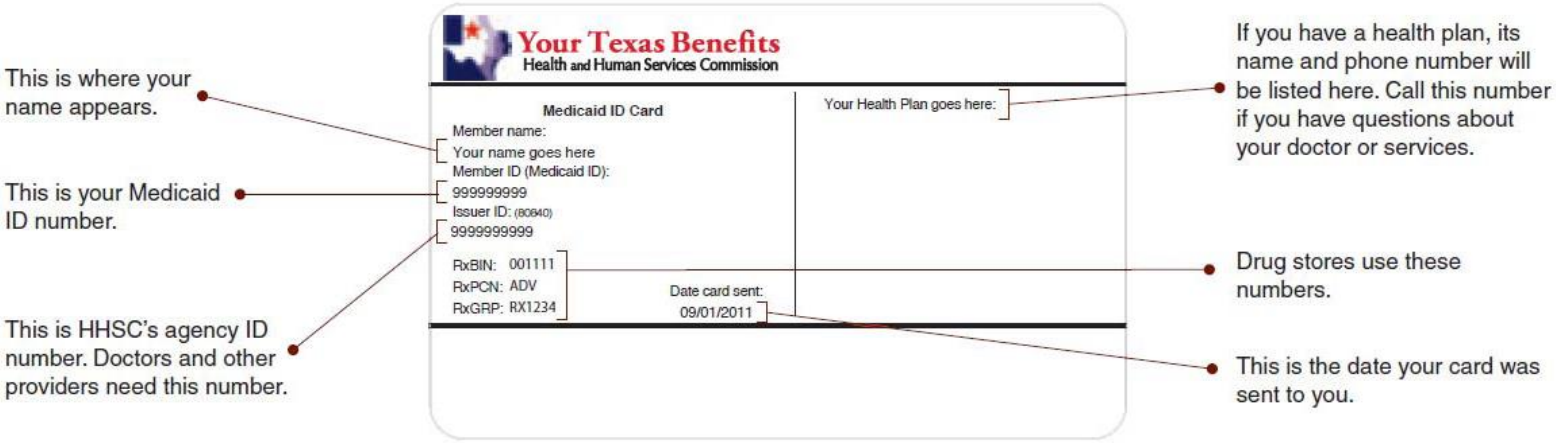


Test Data/Test Environment

Texas Benefits Medicaid Card

The Texas Health and Human Services Commission now uses digital technology to streamline verifying eligibility and accessing a member's Medicaid health history. The two main elements of the system are:

- The Your Texas Benefits Medicaid card.
- An online website where Medicaid providers can get up-to-date information on a patient's eligibility and history of services and treatments paid by Medicaid.
- Aetna Members should present: Your Texas Benefits Card and Aetna Medicaid ID Card



Aetna Better Health

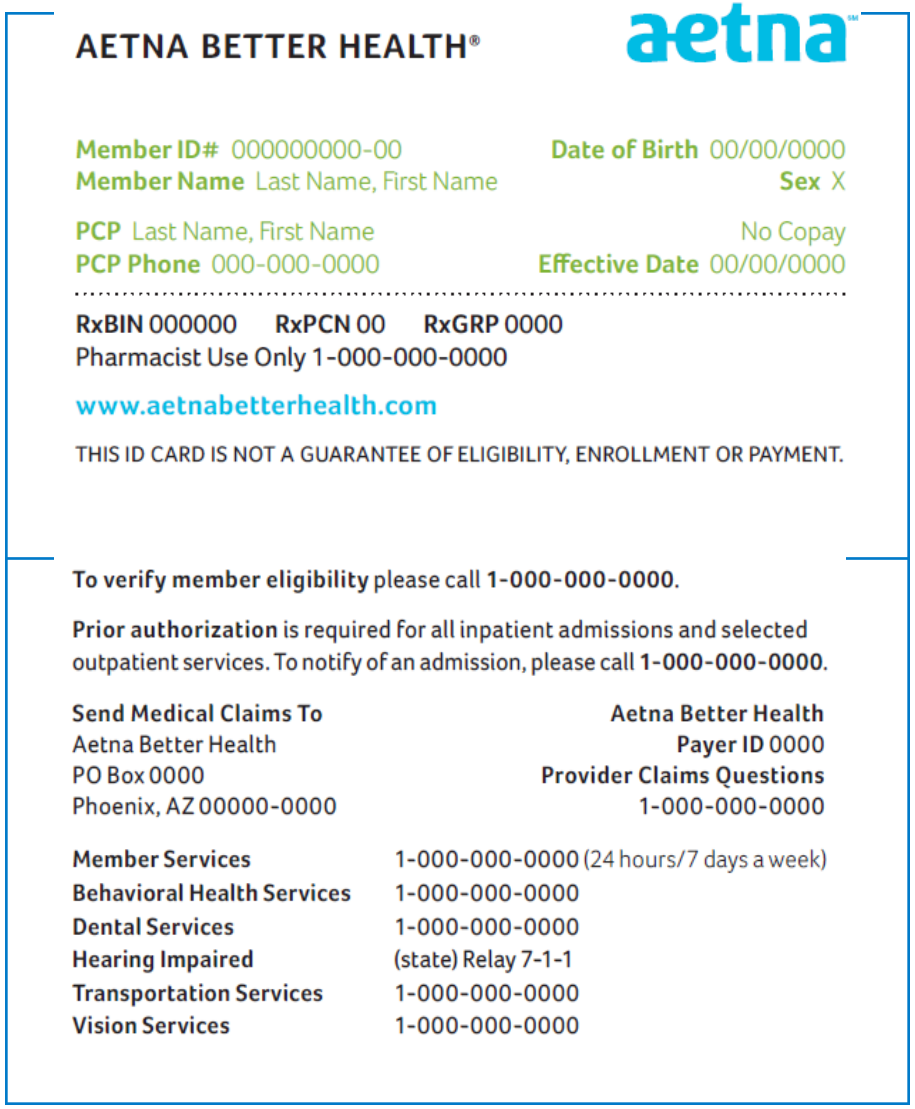
Identification Cards

- All Aetna Better Health members receive an ID card, in addition to a Your Texas Benefits Medicaid card from the State.

- The plan ID card contains the following information:
  - Member's name and Medicaid ID number
  - Medicaid program (e.g., STAR, CHIP or STAR Kids)
  - Aetna Better Health name
  - PCP name and phone number
  - Toll-free phone numbers for member services and behavioral health services hotline

Sample ID Cards

Front →



AETNA BETTER HEALTH®

aetna℠

Member ID# 000000000-00
Member Name Last Name, First Name

Date of Birth 00/00/0000
Sex X

PCP Last Name, First Name
PCP Phone 000-000-0000

No Copay
Effective Date 00/00/0000

RxBIN 000000 **RxPCN** 00 **RxGRP** 0000
Pharmacist Use Only 1-000-000-0000

www.aetnabetterhealth.com

THIS ID CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.

To verify member eligibility please call **1-000-000-0000.**

Prior authorization is required for all inpatient admissions and selected outpatient services. To notify of an admission, please call **1-000-000-0000.**

Send Medical Claims To
Aetna Better Health
PO Box 0000
Phoenix, AZ 00000-0000

Aetna Better Health
Payer ID 0000
Provider Claims Questions
1-000-000-0000

Member Services	1-000-000-0000 (24 hours/7 days a week)
Behavioral Health Services	1-000-000-0000
Dental Services	1-000-000-0000
Hearing Impaired	(state) Relay 7-1-1
Transportation Services	1-000-000-0000
Vision Services	1-000-000-0000

← Back

Clearinghouse & Clean Claims

- We accept both paper and electronic claims
- Change Healthcare (formerly Emdeon) is preferred clearinghouse for electronic claims
  - EDI claims received directly from Change Healthcare
  - Processed through pre-import edits to:
    - Evaluate data validity
    - Ensure HIPAA compliance
    - Validate member enrollment
    - Facilitate daily upload to Aetna Better Health system

Aetna Better Health Claim Submission

- Aetna Better Health encourages participating providers to electronically submit claims through Change Healthcare (formerly Emdeon). You can submit claims by visiting Change Healthcare at https://www.changehealthcare.com/ . Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with Change Healthcare.

- Please use the following Payer ID when submitting claims to Aetna Better Health:

- Change Healthcare (formerly Emdeon) – Use Payer ID 38692

- If your electronic billing vendor is unable to convert to 38692, you may have them continue to use the Aetna commercial Payer ID 60054. If using this payer ID, we recommend that you use “MC” prior to the member number to make sure the claims are processed correctly.

Claim Submission (cont.)

- Providers must file claims within 95 days of the date of service (DOS)

- If your electronic billing vendor can convert to 38692, but doesn't submit directly to Change Healthcare, we recommend that you use "MC" prior to the member number to make sure the claims are processed correctly.

Paper Claims: (eff 3/2022)
Aetna Better Health - Texas and CHIP (TXMS)
P.O. Box 982964
El Paso, TX 79998-2964

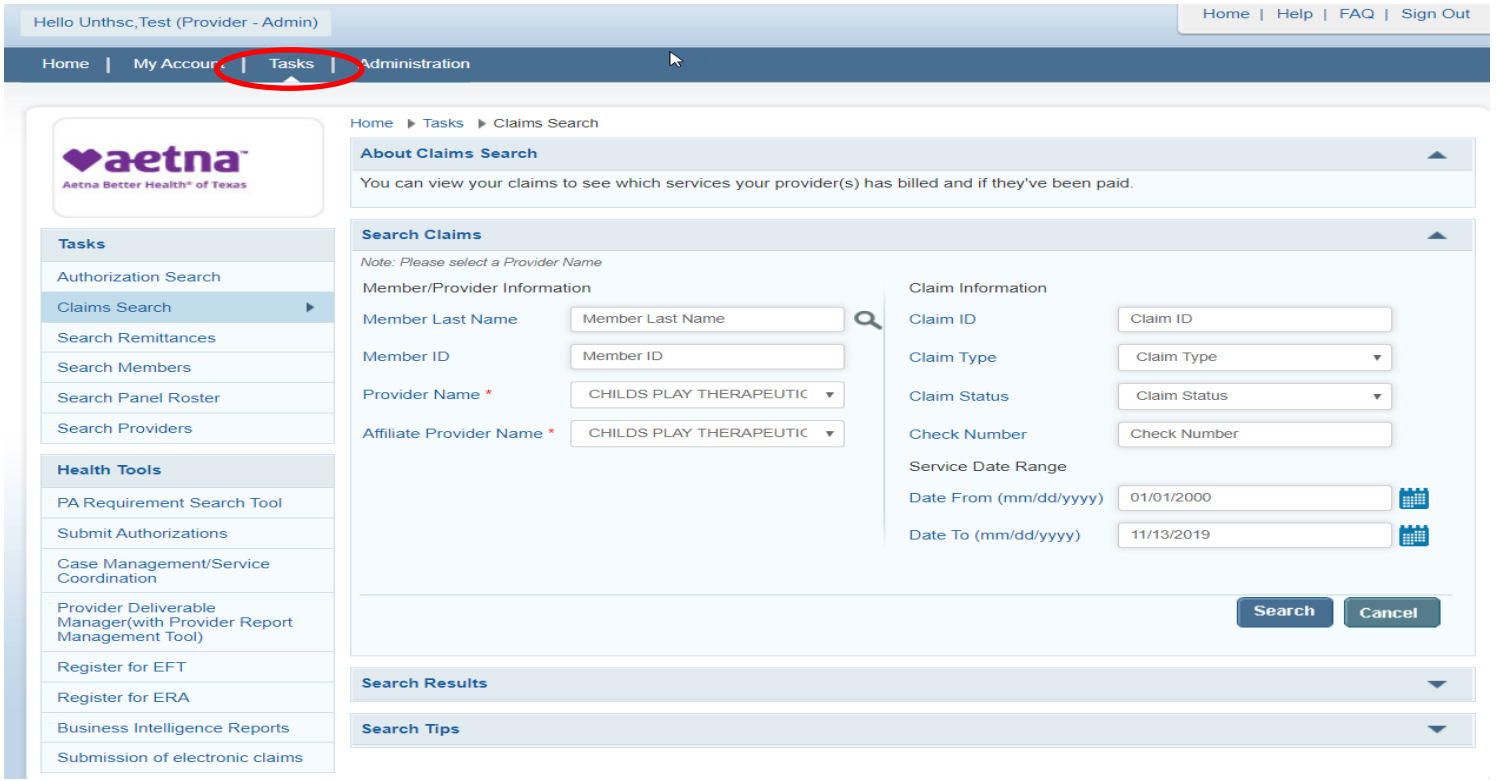
Clearinghouse & Clean Claims (cont.)

- 98% of all claims filed within 30 days of receipt
- 99% of all clean claims within 90 days of receipt.

A "clean claim" is a claim that can be processed without obtaining additional information from the provider of a service or from a third party.

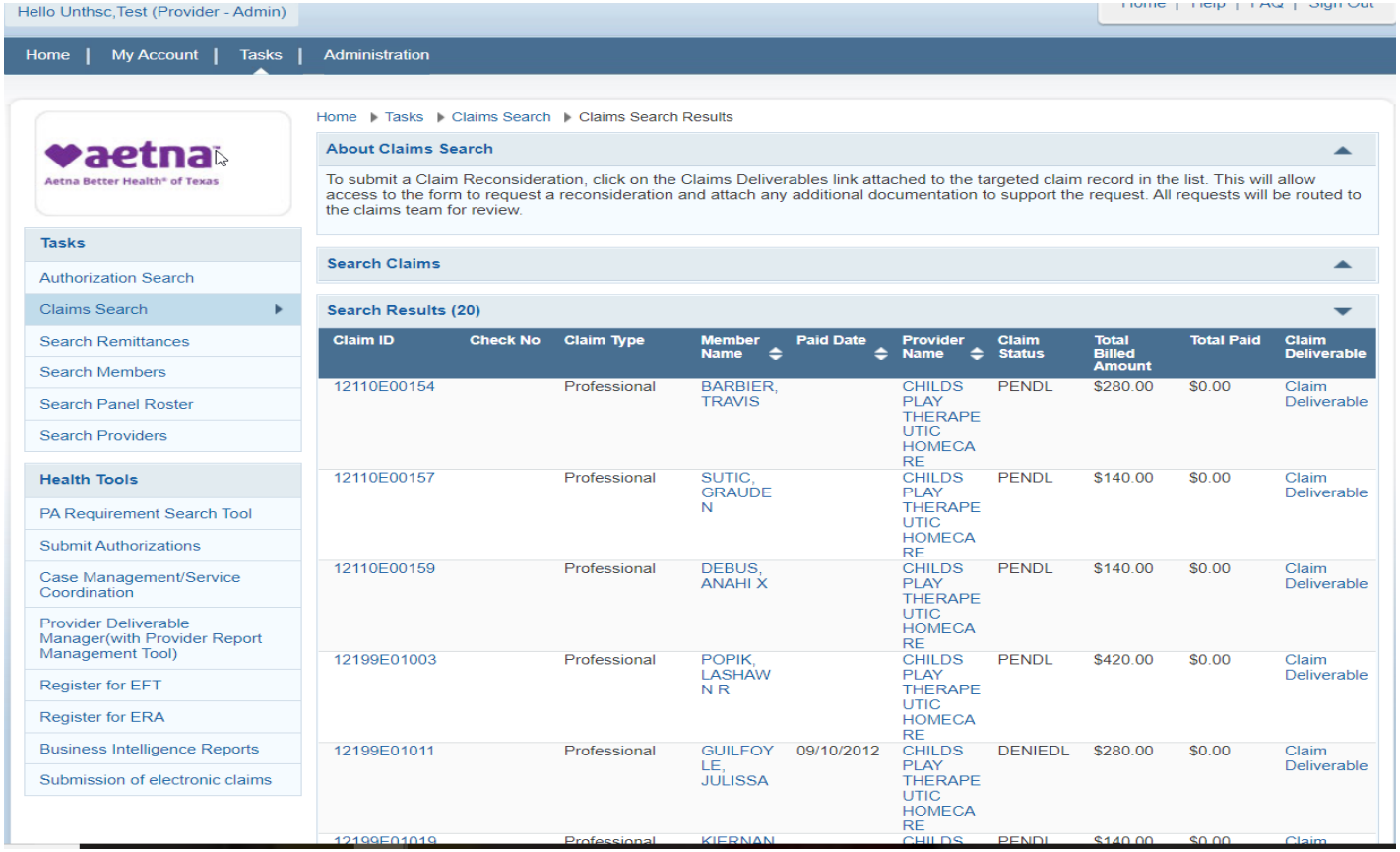
- **Please note:** *All providers must adhere to federal financial protection laws and are prohibited from balance billing any member beyond the member's cost sharing.*

How to check status of claims submitted



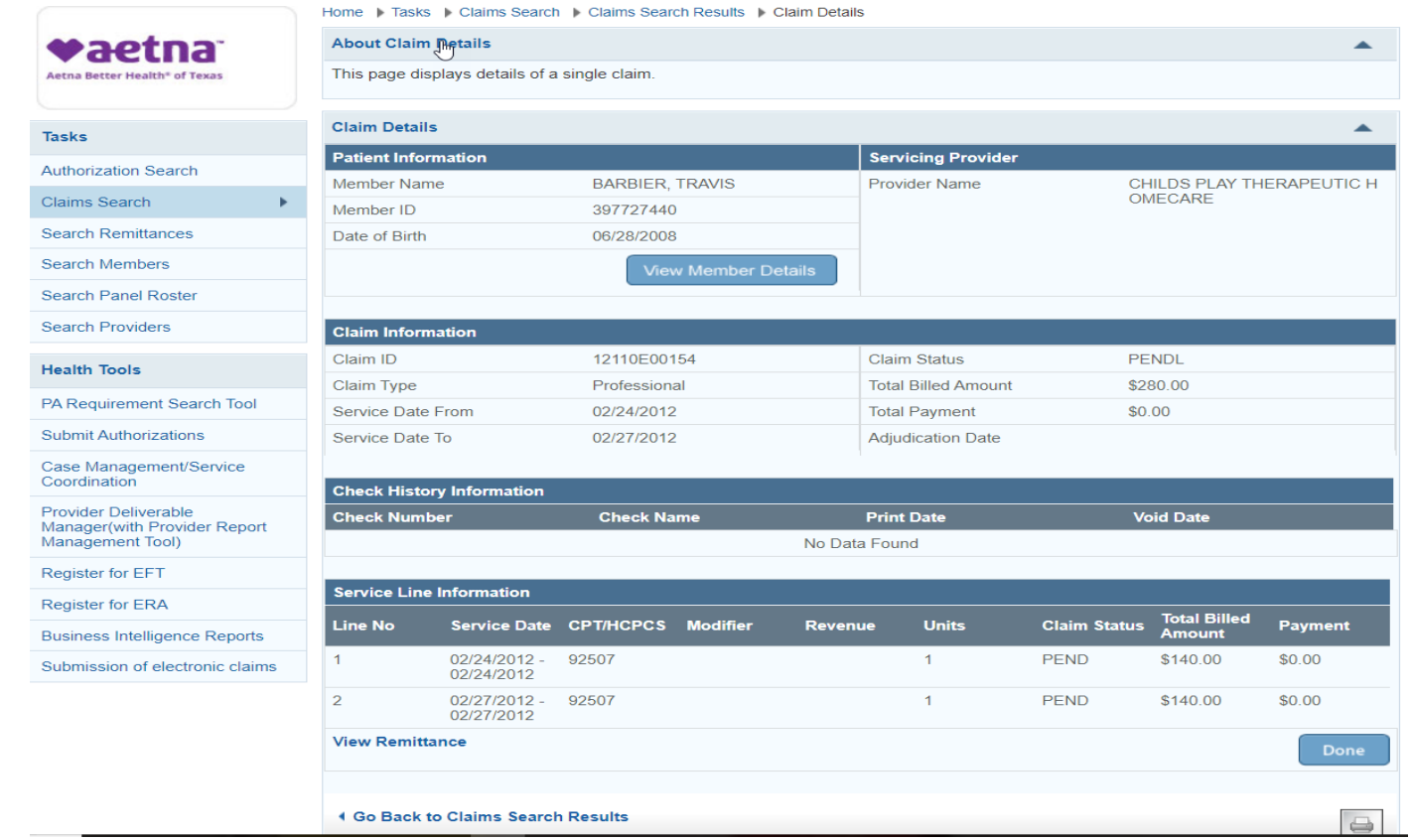
Test Page/Test Environment

How to check status of claims results



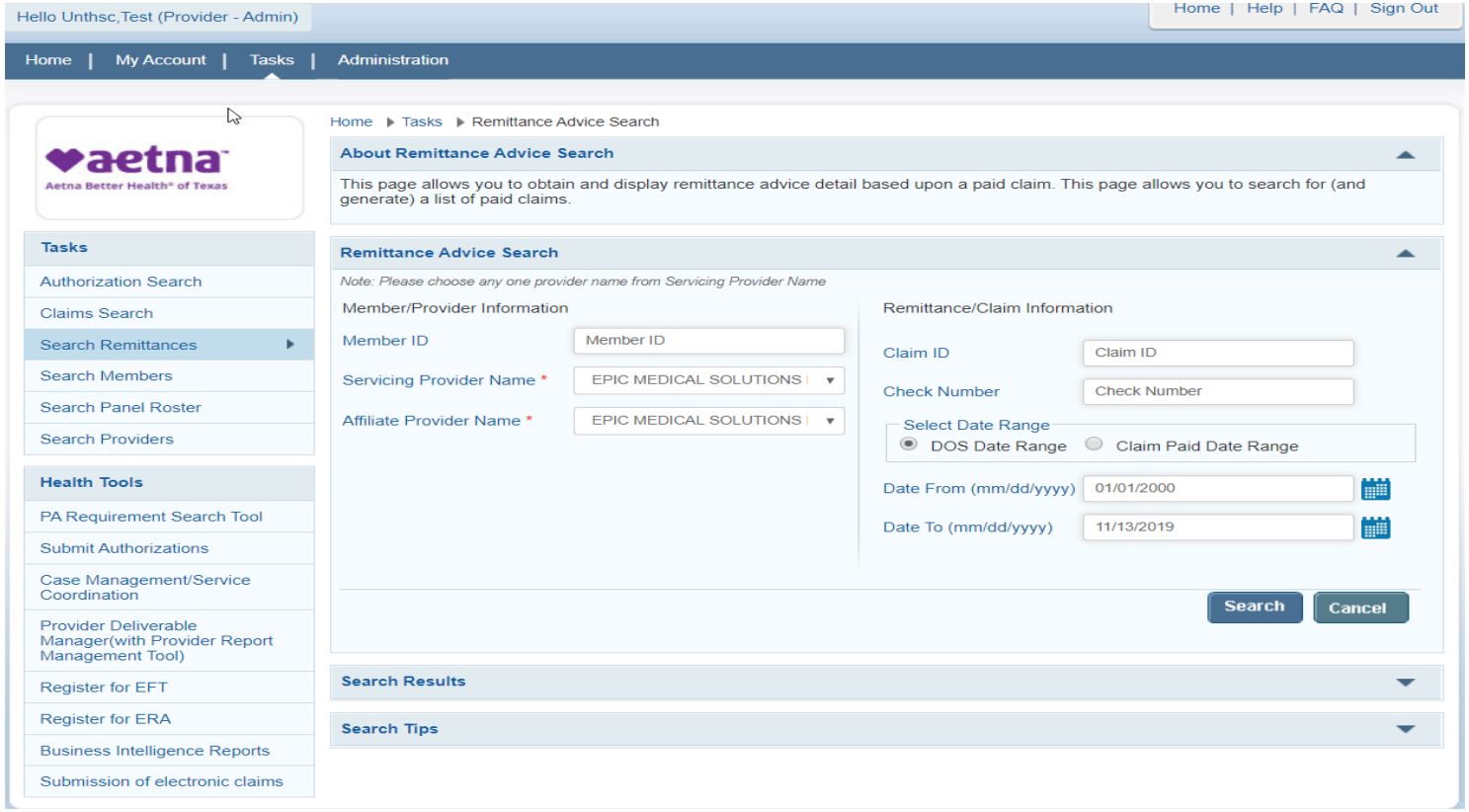
Test Page/Test Environment

View claims results



Test Page/Test Environment

How to Print Explanation of Benefits



Test Page/Test Environment

How to Print Explanation of Benefits cont'd

Test Page/Test Environment

Claim Submission

- Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.

  - How to fill out a CMS 1500 Form:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf

  - Sample CMS 1500 Form:

http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500805.pdf

  - How to fill out a CMS UB-04/1450 Form:

    http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf

STAR Kids LTSS Claims

STAR Kids and LTSS/Medicare EOB Requirements

- (1) For dual-eligible clients, Aetna Better Health of Texas does not require an EOB prior to covering benefits not covered by Medicare.

- (2) For non-dual-eligible clients with primary private insurance, Aetna Better Health of Texas does not require a written EOB (e.g., does not require an EOB at all or may accept a verbal denial) for LTSS or other services not covered under a commercial insurance plan, including: PCS, CFC, DAHS, PPECC, MDCP, and mental health rehabilitation services, and mental health targeted case management services.

Medicaid- Appeals and Fair Hearings

- Members may appeal to the Aetna Better Health and/or file a fair hearing request with the HHSC if services are denied, reduced, or terminated.
- Services may continue during the review if the appeal or fair hearing is requested within the adverse action period and the member requests continued services pending the appeal.

Adverse Benefit Determination include:

- The denial or limited authorization of a requested service
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide service in a timely manner as determined contractually
- The failure of Aetna to act within contractual timeframes
- The denial of a member's request to obtain services outside of Aetna's contracting area
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

External Medical Review and Independent Review Organization

- **External Medical Review (EMR**)- is an independent review of the relevant information that ABH used related to an Adverse Benefit Determination based on functional necessity or medical necessity.
- **Independent Review Organization (IRO)-** is a third-party organization contracted by HHSC that conducts an External Medical Review (EMR) during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity
- Created from SB1207 & SB1096
- **Member Responsibilities & Options:** include Internal Appeal and Continuation of Services with specific criteria. Members have the option to request an EMR and/or State Fair Hearing.
- For more detailed information regarding Member Responsibilities and Options, please refer to HHSC EMR Provider Training included at the end of this section.

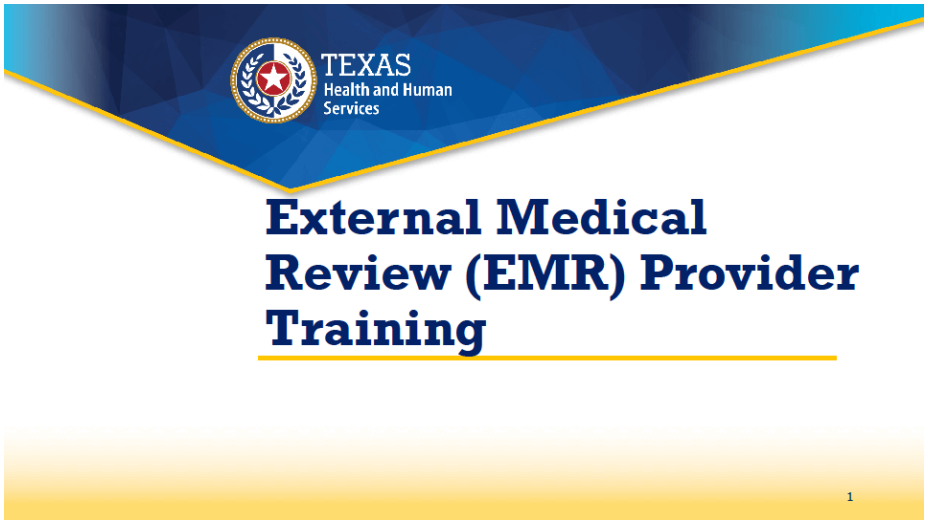
External Medical Review and Independent Review Organization-continued

- Provider Responsibilities:
  - Submit all supporting documentation to substantiate the member's needs, at the time that the services are requested. Examples:
    - Service request (including prior authorizations)
    - Supporting clinical documentations
    - Documentation of any phone calls with MCO
  - Reach out to ABH if unsure of the process or what documentation is required when a member appeals an adverse benefit determination.

External Medical Review and Independent Review Organization-continued

- In addition to Member and Provider actions, HHSC and the IRO have specific responsibilities they will need to complete in this process.
- For more detailed information please refer to the attached PowerPoint presentation from HHSC.
- Provider Training

https://attendee.gotowebinar.com/recording/4623254401546558726



Provider Complaints

- Providers are to contact Aetna Better Health to file a complaint and must exhaust the health plan resolution process before filing a complaint with HHSC.

- •Appeals, grievances, or dispute resolution is the responsibility of the Aetna Better Health.

- •Providers may file complaints with HHSC if they did not receive full due process from the Aetna Better Health .

Member Complaints and Appeals

- Aetna Better Health use appropriately trained pediatric providers for the purposes of reviewing all medically-based member complaints and appeals, such as:

- Member appeals regarding a benefit denial or limitation.

- Member complaints about the:
  - Quality of care or services
  - Accessibility or availability of services
  - Claims processing

Billing Members – Medicaid

- **Providers may not bill or require payment from Members for Medicaid covered services.**

Providers may not bill, or take recourse against Members for denied or reduced claims for services that are within the amount, duration, and scope of benefits of the STAR Program. For more information, please refer to the current Texas Medicaid Provider Procedure's Manual found on the TMHP website at www.tmhp.com

Electronic Remittance Advice and Electronic Funds Transfer Enrollment – STAR, CHIP & STAR Kids

Updated 3/8/23

- Aetna Better Health is partnering with Change Healthcare to introduce the new EFT/ERA Registration Services (EERS.)

- EERS offers providers a standardized method of electronic payment and remittance while also expediting the payee enrollment and verification process. Provider will be able to us the Change Healthcare tool to manage EFT and ERA enrollments with multiple payer on a single platform.

Electronic Remittance Advice and Electronic Funds Transfer Enrollment- Cont'd.

Updated 3/8/23

How and when to enroll?

- For new provider enrollment to EERS, please visit **https://payerenrollservices.com/**.
- Providers currently enrolled with ABHTX EFT/ERA will not be impacted by this.
- For questions or concerns, please visit the Change Healthcare FAQ page or Contact Change Healthcare at **1-800-956-5190** (Monday-Thursday, 8AM-5PM CT).

Referral Process for Aetna Better Health – Medicaid and CHIP

In-network referrals are no longer required for most procedures.

Exceptions for PCP other than PCP of record.

PCP sends universal referral form to specialist with all pertinent information, including test results, etc., if available
Refer to the Prior Authorization list for exceptions for specific specialty care requirements

Specialist provides follow-up information to PCP post visit.
Refer to Prior Authorization list for procedures that require precertification.

Prior Authorization Process for Aetna Better Health – Medicaid and CHIP

Participating Provider submits TX Universal Authorization Form to request services on Prior authorization list

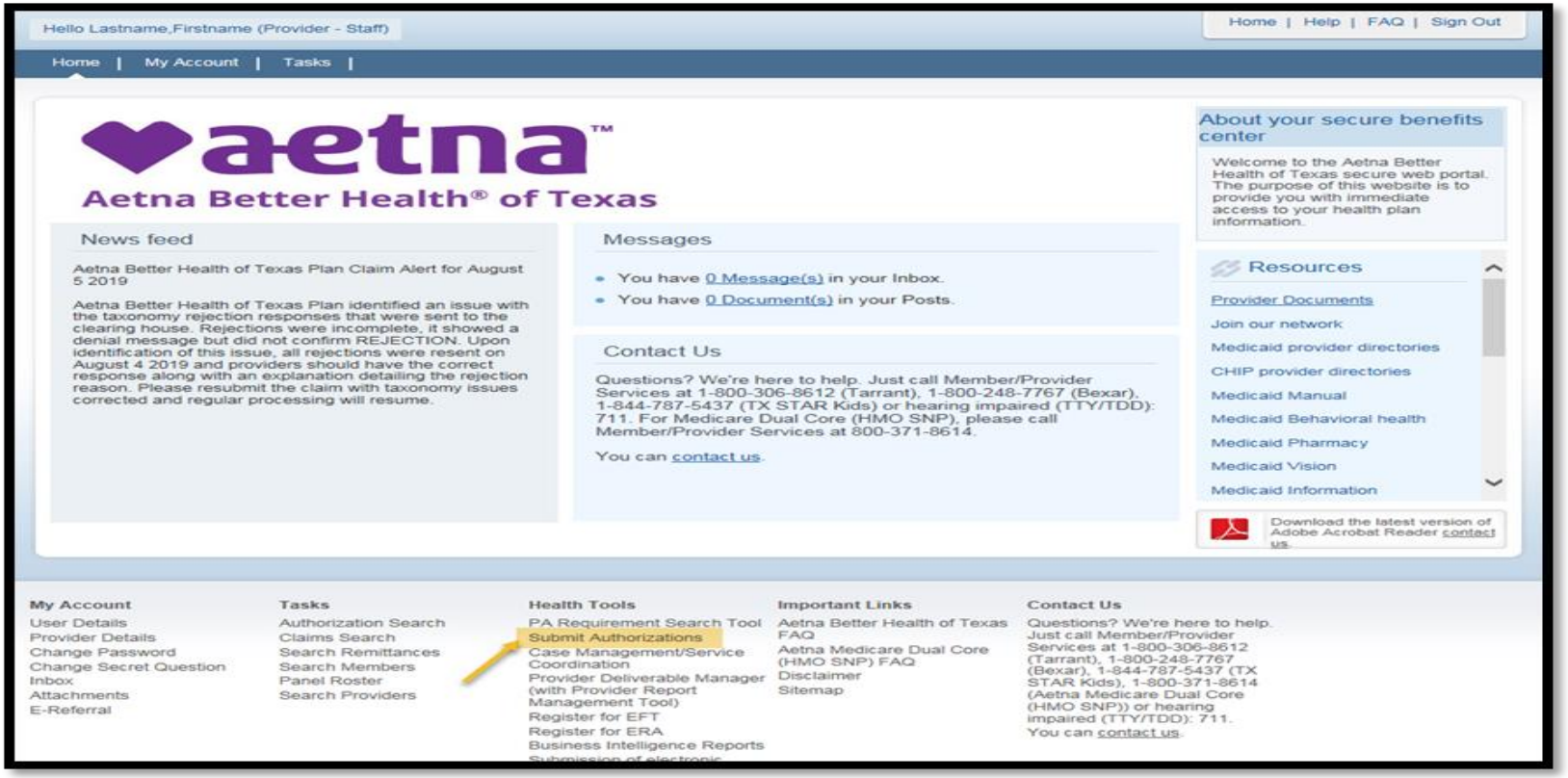
PCP may request a Prior Authorization via:
- Fax using universal referral form
- Web Portal Submission

Aetna Medical Management receives information and reviews eligibility, benefits and medical necessity and returns authorization to requesting provider

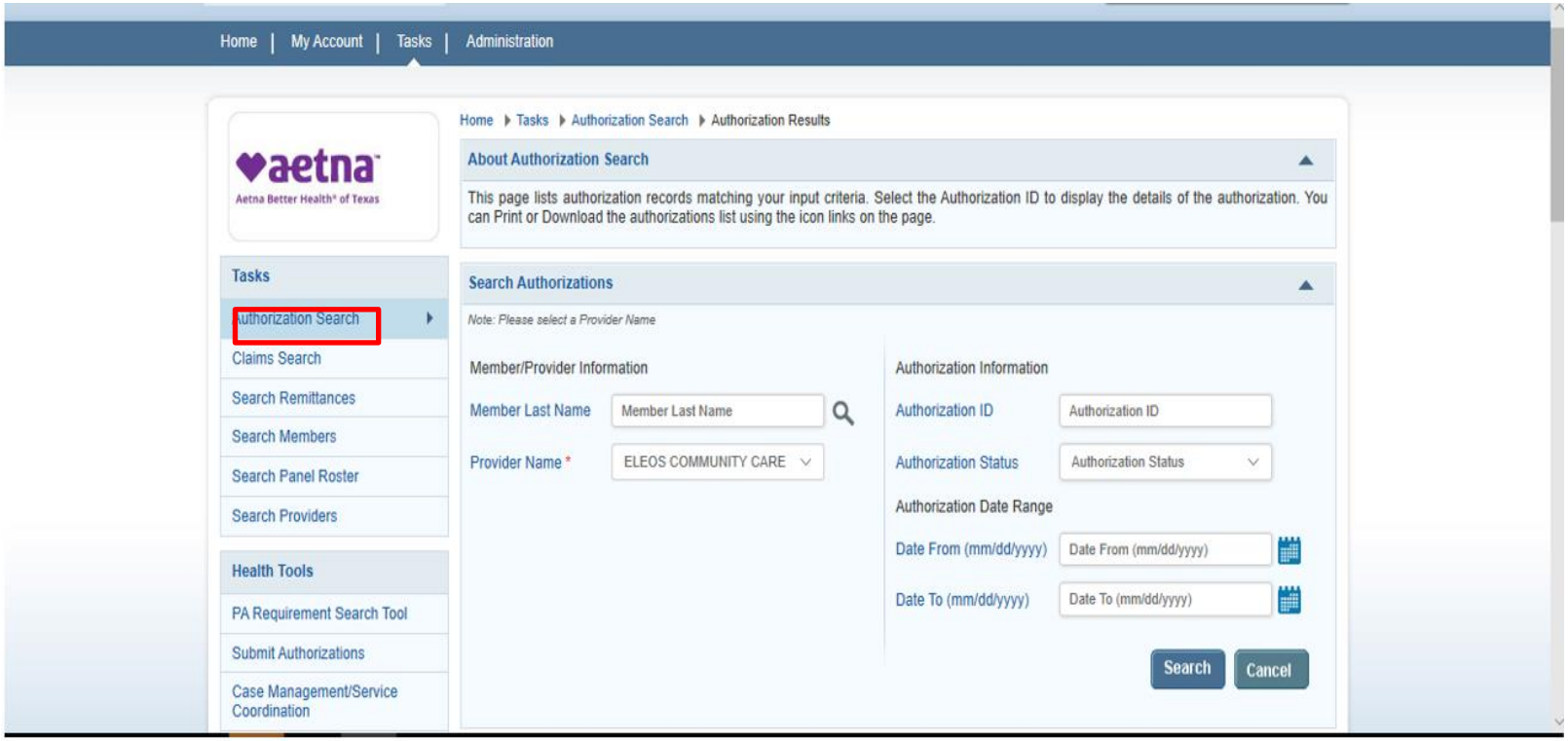
Rendering provider sends information to PCP post visit

Electronic PA Submission Tool – landing page

Medicaid Web Portal Home Page and highlighted link which will launch the new electronic prior authorization form.

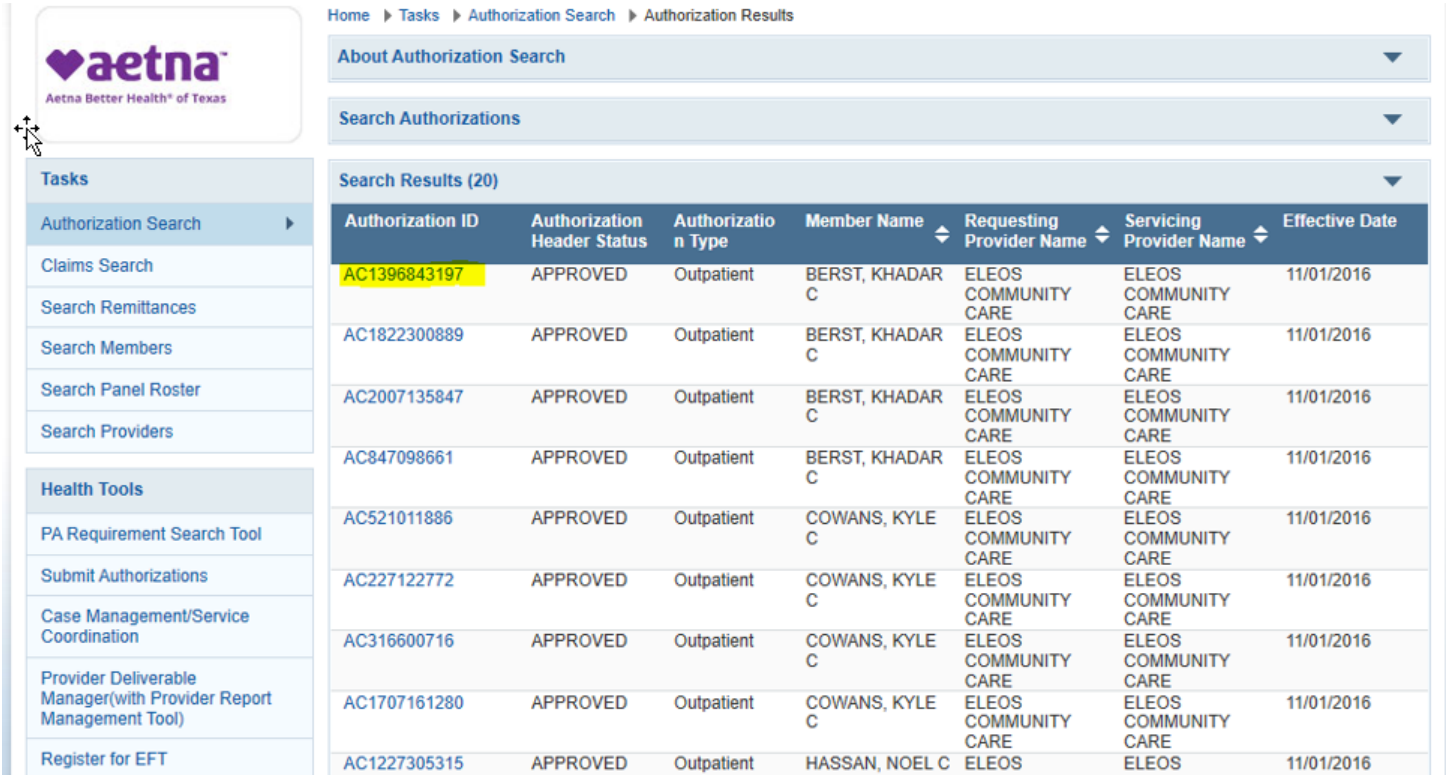


Authorization Search Criteria



Testing Page/Test Environment

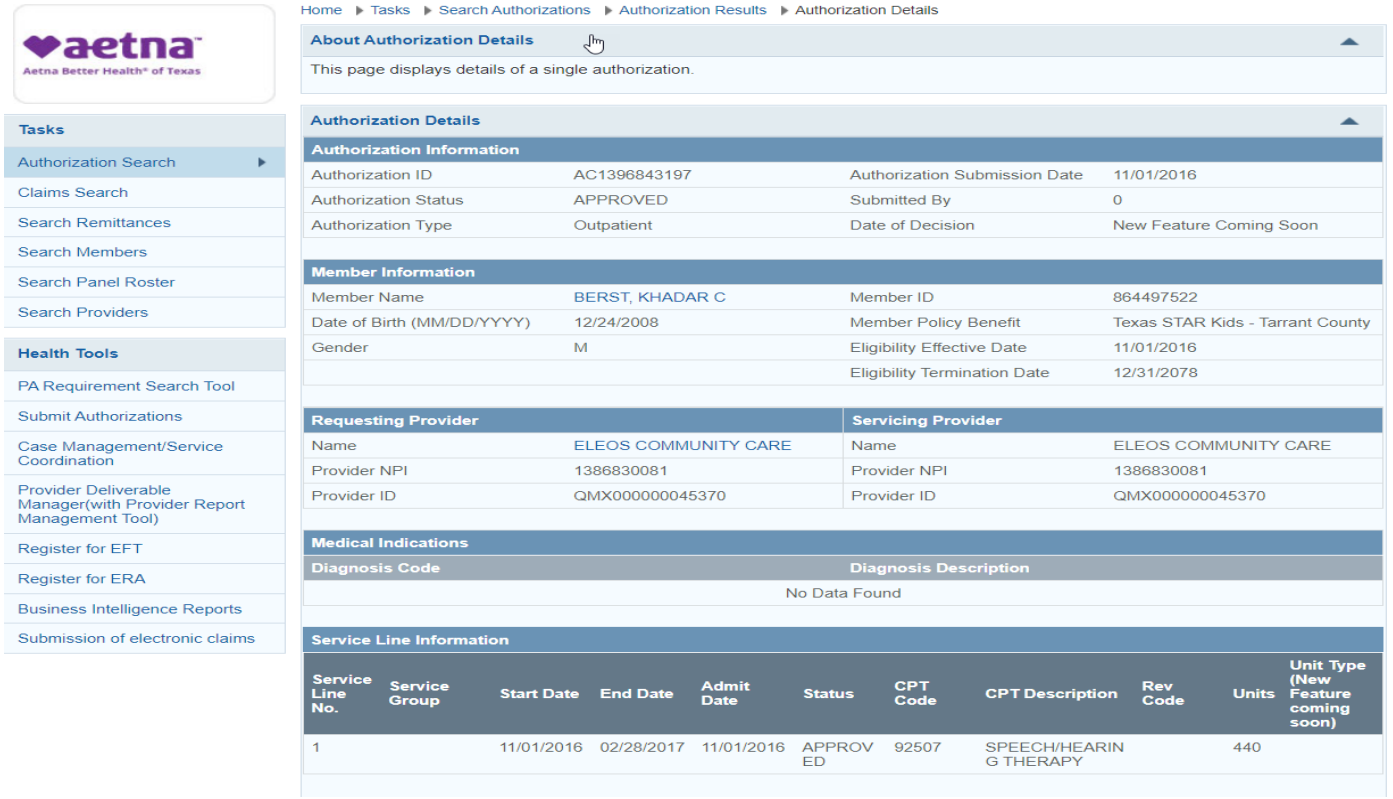
Authorization Search Results



Authorization ID	Authorization Header Status	Authorization Type	Member Name	Requesting Provider Name	Servicing Provider Name	Effective Date
AC1396843197	APPROVED	Outpatient	BERST, KHADAR C	ELEOS COMMUNITY CARE	ELEOS COMMUNITY CARE	11/01/2016
AC1822300889	APPROVED	Outpatient	BERST, KHADAR C	ELEOS COMMUNITY CARE	ELEOS COMMUNITY CARE	11/01/2016
AC2007135847	APPROVED	Outpatient	BERST, KHADAR C	ELEOS COMMUNITY CARE	ELEOS COMMUNITY CARE	11/01/2016
AC847098661	APPROVED	Outpatient	BERST, KHADAR C	ELEOS COMMUNITY CARE	ELEOS COMMUNITY CARE	11/01/2016
AC521011886	APPROVED	Outpatient	COWANS, KYLE C	ELEOS COMMUNITY CARE	ELEOS COMMUNITY CARE	11/01/2016
AC227122772	APPROVED	Outpatient	COWANS, KYLE C	ELEOS COMMUNITY CARE	ELEOS COMMUNITY CARE	11/01/2016
AC316600716	APPROVED	Outpatient	COWANS, KYLE C	ELEOS COMMUNITY CARE	ELEOS COMMUNITY CARE	11/01/2016
AC1707161280	APPROVED	Outpatient	COWANS, KYLE C	ELEOS COMMUNITY CARE	ELEOS COMMUNITY CARE	11/01/2016
AC1227305315	APPROVED	Outpatient	HASSAN, NOEL C	ELEOS	ELEOS	11/01/2016

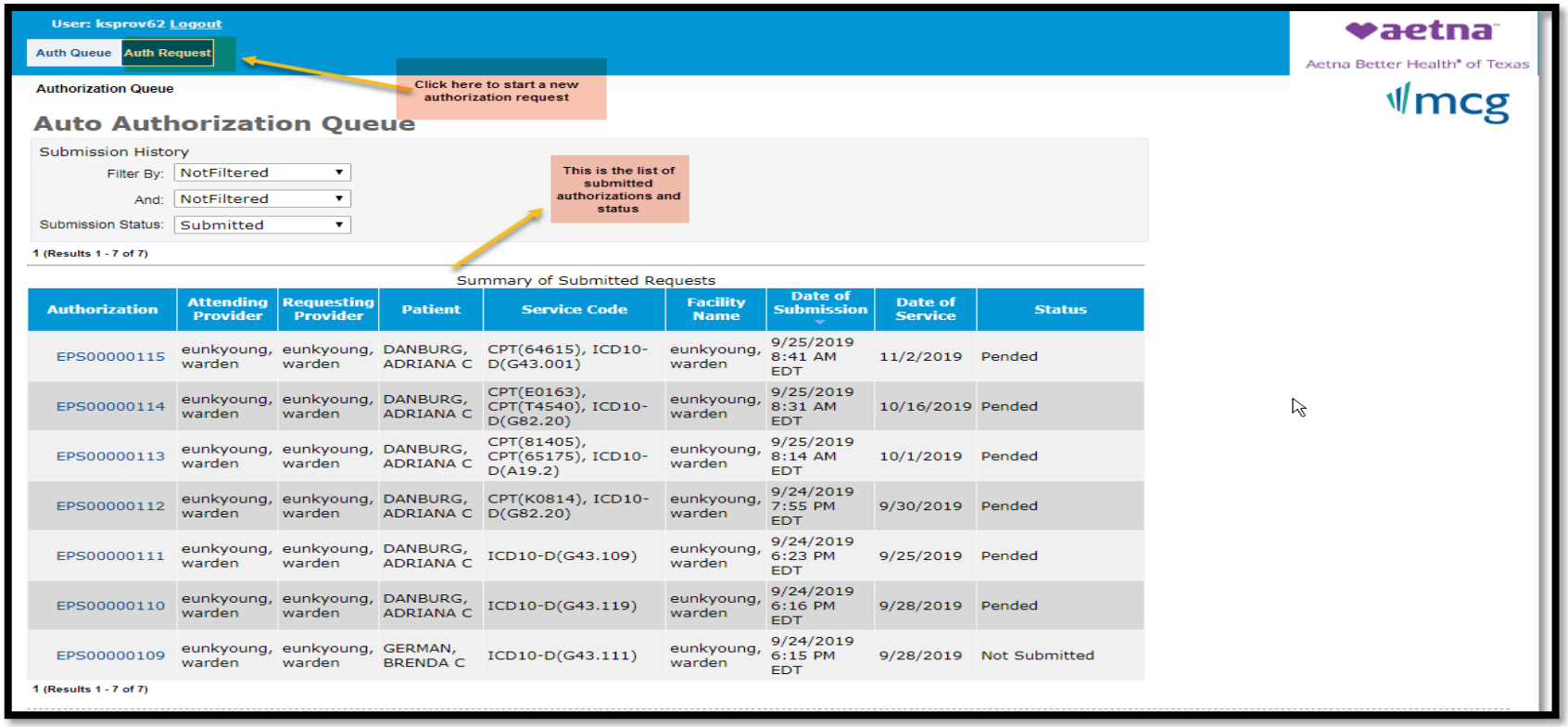
Test Page/Test Environment

Authorization Search Results



Test Page/Test Environment

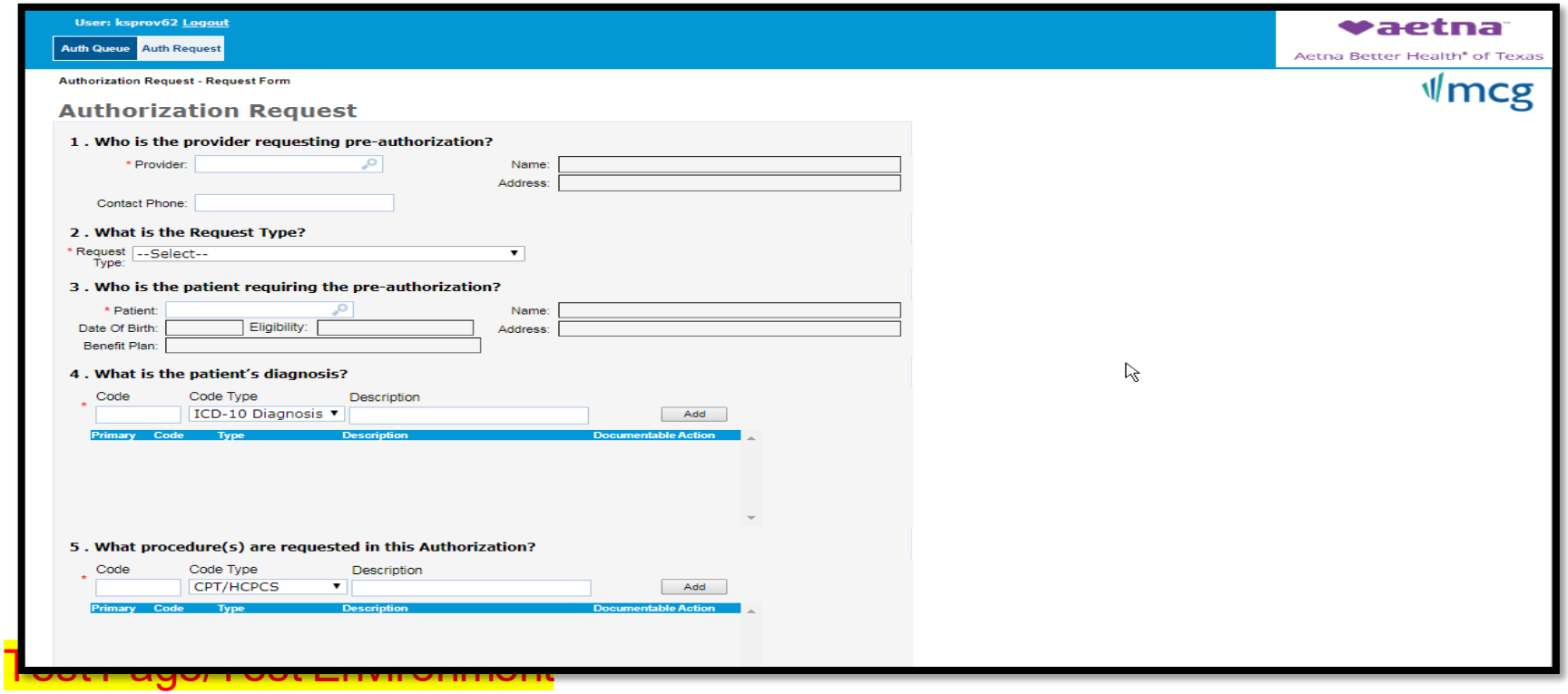
Submission of Prior Authorization



Test
Page/Test
Environment

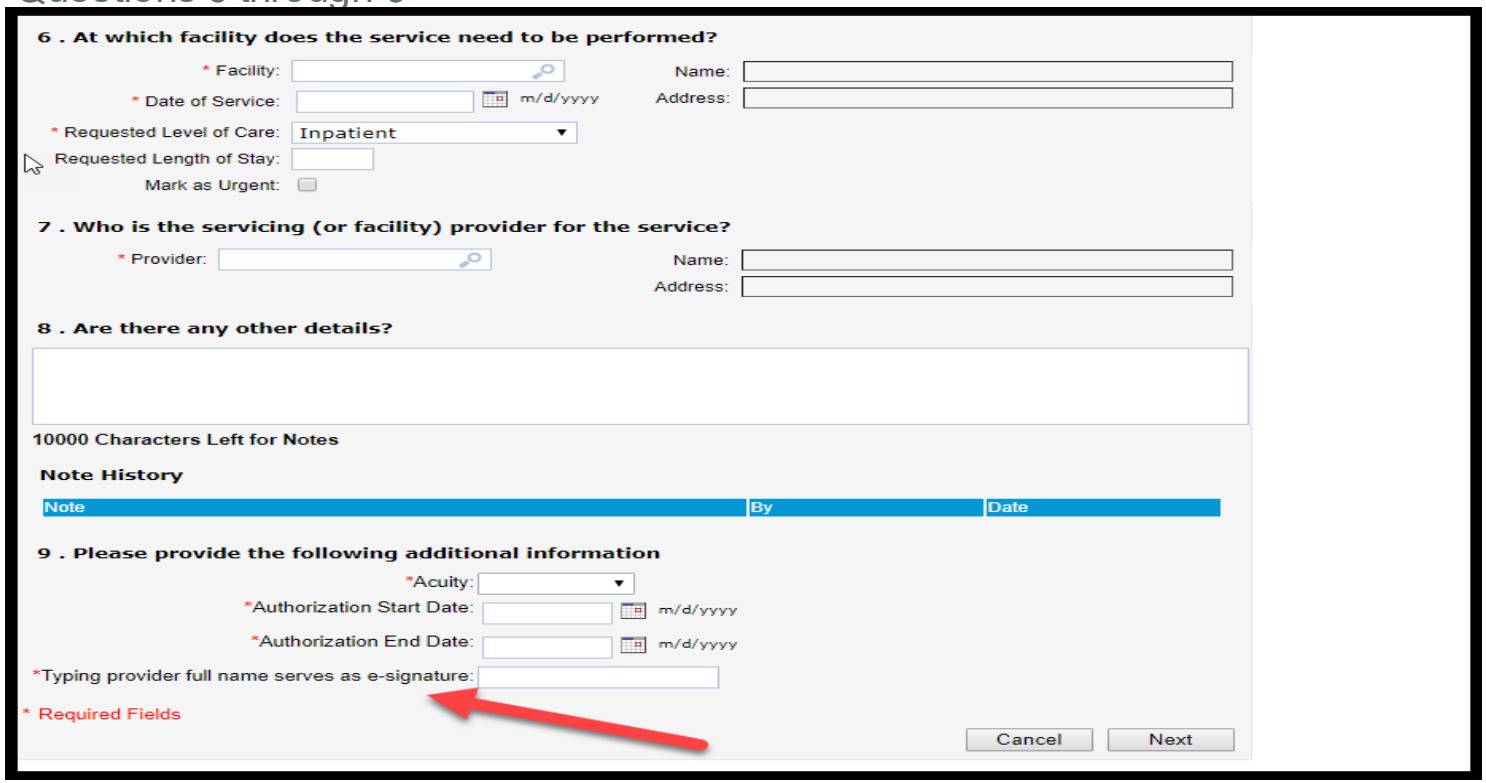
Submission of Prior Authorization cont'd

After clicking on 'Auth Request', following electronic form loads to electronically capture PA request: Questions 1 through 5



Submission of Prior Authorization cont'd

Questions 6 through 9



Test Page/Test Environment

Submission of Prior Authorization cont'd

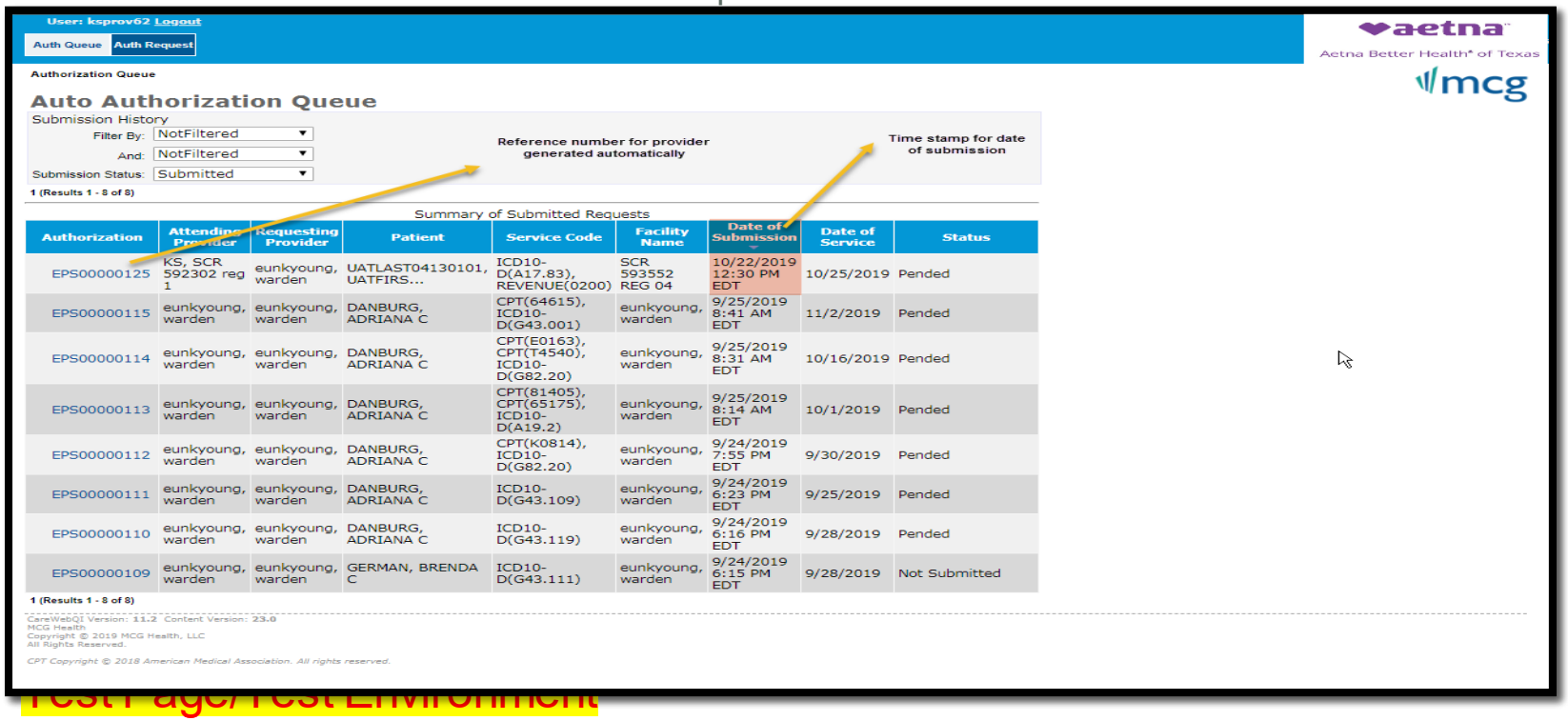
After submitting required information and hitting next, following page loads:

After adding the clinical documentation, entering full name, provider can click 'SUBMIT'

Test Page/Test Environment

Prior Authorization Submission Confirmation

After clicking 'Submit', user is redirected to home page with the recently submitted authorization being shown with a reference number and time stamp of when it was submitted:



Test Page/Test Environment

Provider Prior Authorization Requirement Search Tool

Aetna Better Health of Texas now has a prior authorization requirement search tool that is available directly through the public facing website. Providers don't have to login into the Medicaid Web Portal to access this feature. New look up tool offers:

- ✓ Capability to determine prior authorization requirements by program
- ✓ Captures all Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System(HCPCS) codes
- ✓ Simultaneously enter up to 6 CPT Codes and determine PA requirements
- ✓ Obtain detailed information including – covered or non-covered detail, prior authorization requirements, service partner detail if the code is managed by a sub-contractor
- ✓ Easily locate phone numbers for not just Aetna Better Health of Texas but also all subcontractors responsible for authorizing services for member.

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Aetna Better Health of TX is in partnership with MedSolutions dba eviCore Healthcare to provide authorization services for members regarding certain services such as: CT/CTA, MRI/MRS/MRA, Pet Scans, Non OB Ultrasounds and OB Ultrasounds.

Authorization requests for these services may be submitted online, by phone or fax:

www.medsolutionsonline.com or Call 1-888-693-3211 or Fax 1-888-693-3210
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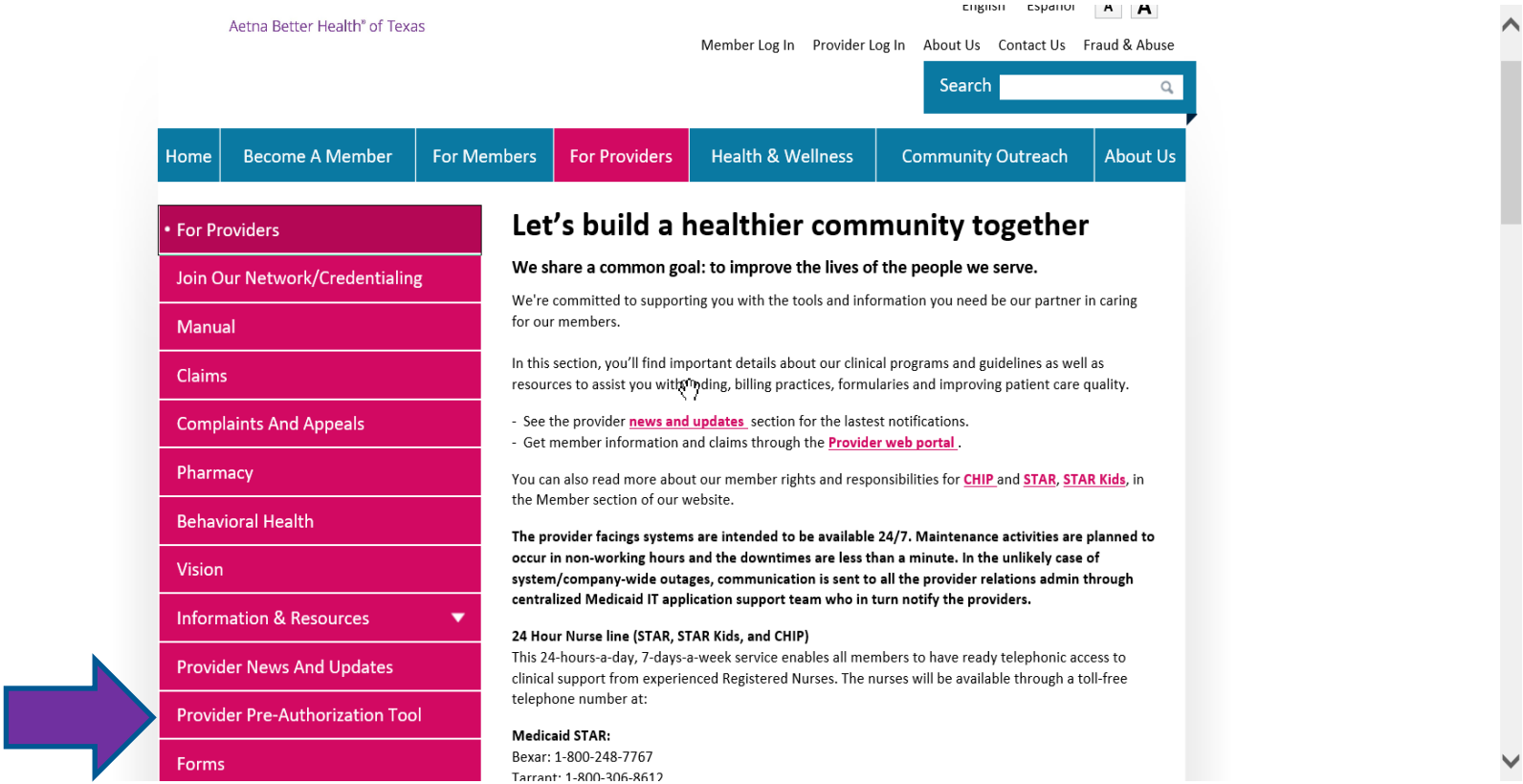
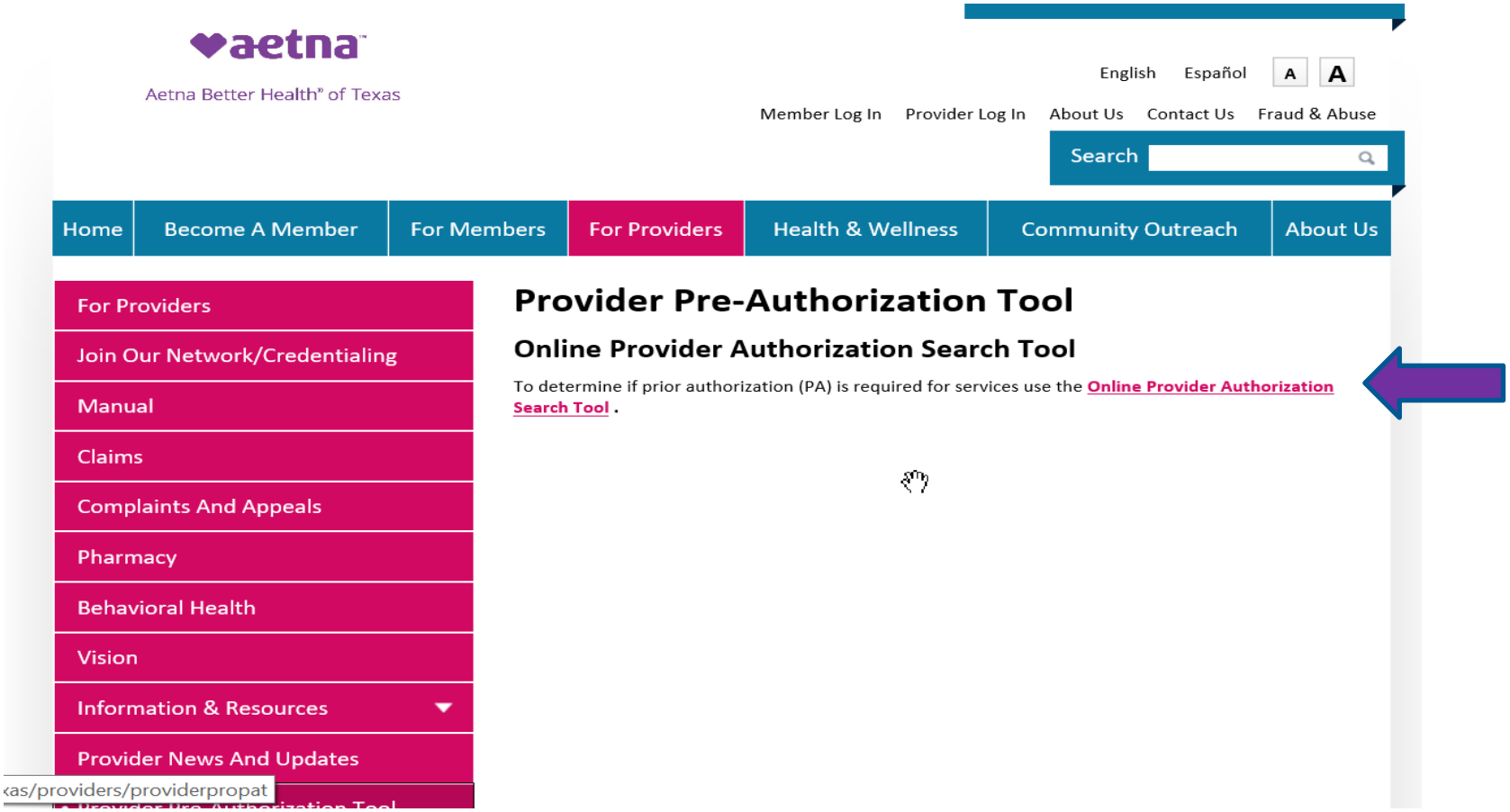
Navigating to the Pre-Prior Authorization Tool



Navigating to the Pre-Prior Authorization Tool



Participating Provider Prior Authorization Requirement Search Tool

aetna

Mon., Jan. 6, 2020

Site Feedback

Aetna Better Health of Texas Participating Provider Prior Authorization Requirement Search Tool

Participating Providers: To determine if prior authorization (PA) is required, enter up to six Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes or a CPT group and select SEARCH. Search result definitions:

YES - Prior authorization request is required for this service.

NO - Health plan does not require a prior authorization request for this service.

NON-COV - CPT or HCPCS code entered is not a covered benefit by health plan.

INVALID - CPT or HCPCS code entered was invalid, not found.

EXPIRED - CPT or HCPCS code entered is no longer valid for use by health plan providers.

Exception Detail, Svc Partner Detail - When the  symbol is displayed for the code, place your cursor over the symbol to review additional information regarding PA submission or service partner requirements.

General Information/Code Search:

- The term Prior Authorization (PA) is the utilization review process used to determine whether the requested service, procedure, or medical device meets the company's clinical criteria for coverage
- Clinical documentation should be uploaded and could potentially cause a delay in services if not uploaded.
- To determine if prior authorization (PA) is required, enter **up to six** Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes or a CPT group and select SEARCH.
- PA requirement results are valid as of today's date only. Future changes to CPT or Healthcare Common Procedure Coding System (HCPCS) codes that require PA will be communicated by Aetna Better Health in writing and on the home page of Aetna Better Health's secure web portal. Aetna Better Health reviews all prior authorization requirements on an annual basis

DISCLAIMER:

- All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices.
- **ProPat authorization tool is NOT place of service specific.**

Recent Enhancements to Provider Portal cont'd

- **To Our Providers:** **Please click here to initiate an electronic prior authorization (ePA) request**
- CVS Caremark Pharmacy Help Desk **1-877-874-3317**.

Services Requiring Prior Authorization:

- Inpatient Hospitalizations/Admissions:
  - All elective admissions to a facility including acute, skilled, hospice, rehabilitation and partial hospitalization for behavioral health conditions. Exception: Well babies (v30.0 who go home with their mothers in less than 3 days for vaginal deliveries or less than 5 days for C-section deliveries).
  - All inpatient facility to facility transfers - the transferring facility is responsible for obtaining precertification prior to the transfer to the new facility.
  - All non-elective admission notification is required. Please submit inpatient notification along with clinical information for medical necessity for admission and level of care within one business day of the admission date.
  - MedSolutions/eviCore is delegated vendor to provide authorization services for CT/CTA; MRI/MRS/MRA; PET Scans; Ultrasounds. Please contact MedSolutions/eviCore for prior authorization of these services by calling 1-888-693-3211. Refer to MSI Announcement under What's New at aetnabetterhealth.com/texas.
  - Prolonged nursery level 1 care (longer than two days for a vaginal delivery or four days for a cesarean section) and All Neonatal/Nursery/Newborn levels of care beyond well nursery level 1, that is Revenue Code 0172, 0173, 0174 and 0175 require PA for payment, regardless of length of stay.
- Durable medical equipment, supplies, prosthetics, orthotics - All requests where the total amount of the request is greater than $1,000 (including but not limited to): Hospital beds Electric scooter Customized braces /orthotics Upper limb prosthetics Lower limb prosthetics Wheelchairs, Cranial molding helmets Hearing aids
- In-office specialty care referrals - Any non-urgent referral for out of network or out of Service Delivery Area specialist office visits, regardless of specialty

Services NOT Requiring Prior Authorization:

- Most office level services do not require pre-authorization. Please verify by submitting the code to confirm and reviewing for any exceptions.
- If you have any questions about authorization requirements or need help with the search tool, contact Aetna Better Health of Texas at
- Tarrant:
  - STAR: 1-800-306-8612, STAR Kids: 1-844-787-5437, CHIP: 1-800-245-5380
- Bexar:
  - STAR: 1-800-248-7767, CHIP: 1-866-818-0959

Enter CPT or HCPCS Code(s)

H2015	T1019	T1000
T2039		

OR Select CPT Group:

Select Plan: STAR Kids

NOTE: When selecting by CPT group, the results displayed include CPT codes where PA requirements are both Yes and No, as specified on the PA List. To reduce the list of CPT or HCPCS codes to only those requiring PA, please check the box labelled "Include only CPT or HCPCS codes where PA is required?".

☐ Include only CPT or HCPCS codes where PA is required?

Recent Enhancements to Provider Portal cont'd

aetnabetterhealth.com/texas.

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☐ Include only CPT or HCPCS codes where PA is required?

Search Clear Export

CPT Code	CPT Description	CPT Group	PA Required?	Variance Detail	Svc Partner Detail
H2015	COMP CMTY SUPPORT SRVC PER 15 MIN	HCPCS - ALCOHOL/DRUG ABUSE	YES		

Prior Authorization Decision Timeframes

Decision	Decision/Notification Timeframe	Notification to	Notification Method
Urgent pre-service approval	Within 24 hours of receipt of necessary information, but no later than 72 hours from receipt of request	Practitioner / Provider	Telephone and in writing
Non-urgent pre-service approval	Within 14 calendar days (or sooner as required by the needs of the member) of receipt of necessary information sufficient to make an informed decision	Practitioner / Provider	Telephone and in writing
Continued / extended services approval (non-ED/acute inpatient)	1 business day of receipt of necessary information	Practitioner / Provider	Telephone and in writing
Post-service approval of a service for which no pre-service request was received.	30 calendar days from receipt of the necessary information	Practitioner / Provider	Telephone and in writing

STAR, CHIP & STAR Kids Medical Prior Authorization

- You may submit prior authorization requests to us 24-hours-a-day, 7-days-a-week through one of the options below:
- **STAR and CHIP Prior Authorization FAX and via Web Portal submission**
  - Fax - Acute/DME/Private Duty Nursing : fax requests to **1-866-835-9589**
    Concurrent review: Fax requests to **1-866-706-0529**

- **STAR Kids Prior Authorization FAX and via Web Portal submission**
  - Fax – Acute/DME/Private Duty Nursing: fax requests to **1-866-835-9589**
  - Fax - Long Term Services and Supports (LTSS): **844-275-5728**
- Please submit the following with each authorization request:
  - Member Information, e.g., correct and legible spelling of name, ID number, date of birth, etc.
  - Diagnosis Code(s)
  - Treatment or Procedure Codes
  - Anticipated start and end dates of service(s) if known
  - All supporting relevant clinical documentation to support the medical necessity
  - Include an office/department contact name, telephone and fax number

STAR Kids Referrals

- Referrals are not needed in-network.
- Members should still let their PCP know they are going to another provider so the PCP can coordinate their care.
- Some services may need to be preauthorized.

Out of Network Referrals:

Occasionally, a member may be referred to an out-of-network provider because of special needs, the qualifications of the out-of-network provider or network deficiency. Aetna Better Health makes such decisions on a case-by-case basis in consultation with Aetna Better Health's medical director.

Behavioral Health Services – Medicaid and CHIP

- Direct Access
  - Members may access BH benefits, without a referral from their PCP.
  - Member Services available 24/7

- PCP involvement
  - Provide screening, evaluation, treatment and/or referrals (as medically appropriate) for any behavioral health problem/disorder
  - Treat for mental health and/or substance abuse disorders with their scope of practice
  - Inform members how and where to obtain behavioral health services

Behavioral Health Services (continued) – Medicaid and CHIP

- Members have direct access to behavioral health providers.
- BH providers must send initial and quarterly (or more frequently if clinically indicated) summary reports to the PCP, with the member or member's legal guardian's consent.
- BH providers must refer members with known or suspected and untreated physical health problems to their PCP for examination and treatment.
- BH providers must be licensed to provide physical health care services.
- Clinical decision making is based on LOCUS, CALOCUS and TCADA standards
- Routine care must be offered within 14 days of request, urgent care within 24 hours and emergency situations must be responded to immediately
- Following an inpatient stay, members should be offered an outpatient follow up appointment within 7 days of discharge
- Screening, brief intervention, and referral to treatment (SBIRT) for substance use related issues is a benefit of Texas Medicaid. ***See Aetna Better Health Provider Manual for further detail.***

Behavioral Health Services (continued) – Medicaid and CHIP

- Substance Use Disorder (SUD) occurs when the recurrent use of alcohol/or drugs causes clinically and functionally significant impairment—includes opioids, such as health problems, disability and failure to meet major responsibilities at work, school, or home.
- Severe emotional disturbance (SED) describes psychiatric disorders in children and adolescents, up to age 18, which cause severe disturbances in behavior, thinking and feeling.

- Prior authorization is not required for routine outpatient therapy.
- Prior authorization is required for these services.
  - Inpatient admissions
  - Residential admission
  - Partial hospitalization admissions
  - Psychological and neurological testing
  - Outpatient ECT
  - Biofeedback
  - Outpatient detoxification
  - Psychiatric home care services
  - Amytal interviews
  - Applied Behavioral Analysis (ABA)
- Prior authorization requests for behavioral health may be faxed into Aetna Better Health. Aetna Behavioral Health Prior Authorization (PA) toll free FAX number is 855-841-8355.
- Aetna Behavioral Health Concurrent Review (CCR) toll free FAX number is 855-857-9932.

Mental Health/Substance Abuse (MH/SA) STAR Kids

In order to meet the behavioral health needs of our members, we will provide a continuum of services to members at risk of or suffering from mental, addictive, or other behavioral disorders.

We endorse early identification of mental health issues so that timely intervention, including treatment and patient education, can occur. To that end, providers are expected to:

- Screen, evaluate, treat and/or refer (as medically appropriate), any behavioral health problem/disorder
- Treat mental health and/or substance abuse disorders within the primary care providers' scope of practice
- Inform members how and where to obtain behavioral health services
- Understand that members may self-refer to an in-network behavioral health care provider without a referral from the member's PCP.

Whenever a PCP is concerned about a member who may have a MH/SA problem, it can be very helpful to have designated screening tools to help the PCP decide whether to take further action. Please refer to the Provider Manual about the tools we use to screen members with possible MH/SA concerns.

Behavioral Health

Is defined as those services provided for the assessment and treatment of problems related to mental health and substance abuse.

These services include but are not limited to: assessment and treatment planning, substance abuse services , medication management , inpatient services, intensive outpatient services, case management services and outpatient therapy.

For more detail on the behavioral health benefits , please refer to the Covered services section in our provider manual (see provider website).

List of Behavioral Health Covered services (not all-inclusive)

Medicaid STAR Kids covered behavioral health services are not subject to the quantitative treatment limitations that apply under traditional, Fee-For-Service (FFS) Medicaid coverage.

The services may be subject to the Aetna Better Health of Texas' non-quantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 behavioral health services, including but not limited to:

- Inpatient mental health services including in Freestanding Psychiatric Facilities for children
- Outpatient mental health services
- Psychiatry services

Attention Deficit Hyperactivity Disorder (ADHD)

- ADHD is one of the most common childhood psychiatric conditions. ADHD is a valid neurobiological condition that causes significant impairment in those whom it afflicts.
- Providers are expected to use appropriate screening for diagnosis.
- Treatment services for children diagnosed with ADHD, including follow-up care for children who are prescribed medications, are covered as outpatient mental health care. Members who are newly prescribed ADHD medication should have at least one follow-up visit within thirty (30) days of the prescription.
- Reimbursement- Claims billed by a physical health provider will be considered for reimbursement by Aetna Better Health of Texas when billed with an ADHD code.

Vision Services – STAR, CHIP & STAR Kids

Vision Services coordinated through Superior Vision 1-800-879-6901

- Direct access
  - Members may access routine vision services, without a referral from their PCP, provided they are coordinated through Superior Vision
- Non-routine vision services
  - PCP can refer directly to a participating ophthalmologist for non-routine vision services
  - In-network ophthalmologists and optometrists may perform non-surgical services within the scope of their licenses without a referral from the member's PCP or an authorization from Aetna Better Health Plan

Pharmacy Coverage

CVS Caremark administers the prescription drug benefit for our members.

- Please review the Provider Manual for copay information
- Pharmacies are required to follow federal and state guidelines surrounding dispensing emergency medications.
- The following document are available online:
  - Preferred Drug List (PDL)
  - Over-the-Counter Drug List
  - Prior Authorization Form
  - Mail Order Form

Pharmacy Coverage – STAR, CHIP & STAR Kids

- Aetna Better Health covers prescription medications as of March 1, 2012
- Pharmacy Benefits are coordinated through CVS Caremark
- Our members can get their prescriptions at no cost (Medicaid) or at low co-pays (CHIP) when:
  - They get their prescriptions filled at a network pharmacy
  - Their prescriptions are on the Preferred Drug List (Medicaid) or formulary (CHIP).

- It is important that you as the provider know about other prescriptions your patient is already taking. Also, ask them about non-prescription medicine or vitamin or herbal supplements they may be taking.

Pharmacy Coverage - Medicaid

- **Preferred Drug List (PDL**
  - You can find out if a medication is on the preferred drug list. Many preferred drugs are available without prior authorization (PA). Check the list of covered drugs on our website at www.aetnabetterhealth.com/texas
  - The Texas **Medicaid** Preferred Drug List is now available on the Epocrates drug information system at https://online.epocrates.com/home.
  - The service is free and provides instant access to information on the drugs covered by the Texas formulary on a Palm, Pocket PC handheld device, or SmartPhone.

Pharmacy Coverage – Medicaid and CHIP

- **Formulary Drug List**

  - The Texas Drug Code Formulary http://www.txvendordrug.com/formulary/formulary-information.shtml) covers more than 32,000 line items of drugs including single source and multi source (generic) products. You can check to see if a medication is on the state's formulary list. Remember before prescribing these medications to your patient that it may require prior authorization.

  - If you want to request that a drug be added to the formulary please contact an Aetna Better Health Provider Representative for assistance at:

Medicaid	**1-800-248-7767 (Bexar)**	**1-800-306-8612 (Tarrant)**
CHIP	**1-866-818-0950 (Bexar)**	**1-800-245-5380 (Tarrant)**

Pharmacy Coverage – Medicaid and CHIP

- **Over the Counter Drugs (OTC)**
  - Aetna Better Health also covers certain over-the-counter drugs if they are on the list. Some of these may have rules about whether they will be covered. If the rules for that drug are met, Aetna Better Health will cover the drug. Check the list of covered drugs at www.txvendordrug.com/pdl/
  - All prescriptions must be filled at a network pharmacy. Prescriptions filled at other pharmacies will not be covered.

Pharmacy Coverage
STAR, CHIP & STAR Kids

- **E-prescribing**
  - Electronic Prescribing (e-prescribing, or eRx), supports a physician's ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy
  - Aetna Better Health Plan and CVS Caremark provide for the submission of both paper and electronic prescriptions.
  - Providers engaged in E-prescribing must do so in accordance with all applicable State and Federal laws

- **Mail order form for your members**
  - While mail order is an option, the use of pharmacy mail order delivery is not required. If you are prescribing a maintenance medication you can assist your patient in completing the MOD form that is available on www.aetnabetterhealth.com/texas

Pharmacy Coverage – Medicaid and CHIP

- **Obtaining Pharmacy Prior Authorization**
  - To obtain a Prior Authorization providers can call CVS Caremark at 1-855-656-0363 or fax an authorization form designed specifically for pharmacy requests. You can download that form at www.aetnabetterhealth.com/texas and fax the request to 1-866-255-7534.
  - Please also include any supporting medical records that will assist with the review of the prior authorization request. For all requests allow 24 hours to complete the authorization process.

Pharmacy Coverage - Medicaid

- **Obtaining a 72 Hour Emergency Fill**
  - Federal and Texas law require pharmacies to dispense a 72-hour emergency supply of a prescribed drug to a Medicaid client when the medication is needed without delay and the prescriber is not available to complete the prior authorization
  - Applies to non-preferred drugs on the Preferred Drug List and any drug that is affected by a clinical PA needing prescriber's prior approval
  - The pharmacy will submit an emergency 72-hour prescription when warranted; this procedure will not be used for routine and continuous overrides
  - For further details on the 72 hour emergency supply requests, please use this link to the State VDP website http://www.txvendordrug.com/downloads/72_hr_emergency_prescriptions.pdf

Supplemental Pharmacy Services

- **Comprehensive Care Program (CCP) - Medicaid**
  - The Medicaid Comprehensive Care Program (CCP) can cover medically necessary drugs and supplies that are not covered by the Vendor Drug Program for members from birth through 20 years of age. Your patients can call TMHP at 1-800-335-8957 to locate a participating CCP pharmacy provider.

- **Durable Medical Equipment – Medicaid and CHIP**
  - Pharmacies are encouraged to provide some limited Durable Medical Equipment (DME) and medical supplies to Medicaid and CHIP plan members. Participating pharmacies are eligible to provide the limited approved DME and medical supplies that are covered under the state of Texas Medicaid and CHIP programs.

Pharmacy Contact Information – Medicaid and CHIP

Reason	Phone Number	Website
Prior Authorization	Call 1-855-656-0363 Fax 1-866-255-7534	www.aetnabetterhealth.com/texas (for form)
Caremark Pharmacy Help Desk (Point of service/ adjudication issues)	1-877-874-3317	www.caremark.com/pharminfo
Aetna Better Health (eligibility verification)	1-800-248-7767 Bexar Medicaid 1-800-306-8612 Tarrant Medicaid 1-866-818-0950 Bexar CHIP 1-800-245-5380 Tarrant CHIP 1-844-STRKIDS or 844-787-5437	www.aetnabetterhealth.com/texas
Texas Vendor Drug Program (for pharmacies only)	1-800-435-4165	www.txvendordrug.com

Ob/Gyn Services - Medicaid

- Female patients have direct access to in-network Ob/Gyn specialists.
- If an Ob/Gyn needs to refer for out-of-network specialty care for related services, the physician must initiate the referral through Aetna Better Health Medical Management unit.
- Aetna Better Health allows Pregnant Members past the 24th week of pregnancy to remain under the care of their current Ob/Gyn through the Member's postpartum checkup, even if the provider is out-of-network. Member may select an Ob/Gyn within the network if she chooses to do so and if the provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

Update to the TMPPM Gynecological, Obstetrics and Family Planning Handbook for LARC and Immediate Postpartum LARC Devices

- Texas Medicaid managed care organizations must provide all medically necessary, Medicaid-covered services to eligible clients. Administrative procedures such as prior authorization, pre-certification, referrals and claims/encounter data filing may differ from traditional Medicaid (fee-for-service) and from MCO to MCO. Providers should contact the client's specific MCO for details.
- Reminder: Procedure codes for LARCs may be reimbursed in addition to the hospital diagnosis related group payment when insertion is performed immediately postpartum.

Update to the TMPPM Gynecological, Obstetrics and Family Planning Handbook for LARC and Immediate Postpartum LARC Devices

- Reminder: Procedure codes for LARCs may be reimbursed in addition to the hospital diagnosis related group payment when insertion is performed immediately postpartum. Language in subsection 2.2.5.4, "Immediate Postpartum Insertion of IUDs and Implantable Contraceptive Capsules" will also be updated regarding immediate postpartum LARC insertion and claims processing procedures as follows:
  - Procedure codes for LARCs may be reimbursed in addition to the hospital diagnosis related group (DRG) payment when insertion is performed immediately postpartum.

    "Immediately postpartum" refers to the following:

Update to the TMPPM Gynecological, Obstetrics and Family Planning Handbook for LARC and Immediate Postpartum LARC Devices

- Insertion within 10-15 minutes of placental delivery for IUDs
- Insertion prior to discharge for implantable contraceptive capsules

- For claims submitted to the Texas Medicaid and Healthcare Partnerships (TMHP) for processing, hospital, and facility providers must submit an outpatient claim with the appropriate procedure code for the contraceptive device in addition to the inpatient claim for delivery services.
- For claims submitted to a Texas Medicaid managed care organization (MCO), providers must follow the MCO's claim processing procedures for reimbursement of immediate postpartum LARC devices in addition to the rate of delivery services.

Update to the TMPPM Gynecological, Obstetrics and Family Planning Handbook for LARC and Immediate Postpartum LARC Devices

- Medicaid MCOs must adopt claim processing procedures to reimburse hospital and facility providers for immediate postpartum LARC devices in addition to the rate for delivery services.

- For more information, call the TMHP Contact Center at 1-800-925-9126.

http://www.tmhp.com/News_Items/2018/01-Jan/1-3-18%20Update%20to%20the%20TMPPM%20Gynecological,%20Obstetrics%20and%20Family%20Planning%20Handbook%20for%20LARC%20and.pdf

CHIP Perinatal Services

- CHIP perinatal provides care to unborn children of pregnant women with household income up to 202% of the federal poverty level (FPL) and who are not eligible for Medicaid. Once born, the child will receive Medicaid or CHIP benefits, depending on their income.
- Coverage begins on the first day of the month in which eligibility is determined. For example, if an application was submitted Feb. 23, 2009, and eligibility was determined March 13, 2009, coverage would start March 1, 2009.
- **Who is eligible?**

  Unborn children of pregnant women who:

  – Have a household income greater than 198% FPL and at or below 202% FPL.
  – Have a household income at or below 202% FPL but do not qualify for Medicaid because of immigration status.
  – Women who are U.S. citizens or qualified immigrants with household income at or below 198% FPL may be eligible for coverage under Medicaid's pregnant women program.

CHIP Perinatal Services Continued…

- CHIP perinatal coverage includes:
- Up to 20 prenatal visits.
  - First 28 weeks of pregnancy — one visit every four weeks.
  - 28 to 36 weeks of pregnancy — one visit every two to three weeks.
  - 36 weeks to delivery — one visit per week.
  - Additional prenatal visits allowed if medically necessary.
- Some laboratory testing, assessments, planning services, education and counseling.
- Prescription drug coverage based on the current CHIP formulary.
- Hospital facility charges and professional services charges related to the delivery. Preterm labor that does not result in a birth and false labor are not covered benefits.
  - For women with income from 199-202% of the FPL:
    - Hospital facility charges paid through the CHIP perinatal health plan.
    - Professional service charges paid through the CHIP perinatal health plan.
  - For women with income at or below 198% FPL (The majority of CHIP perinatal clients are at or below 198% FPL):
    - Professional service charges paid through CHIP.
    - Hospital facility charges paid through Emergency Medicaid.

CHIP Perinatal Services Continued…

Benefits Once the Child is Born

- Two postpartum visits for the mother.
- Depending on the family's income level, hospital facility charges for labor with delivery and the newborn's first hospital admission may or may not be covered by CHIP perinatal. The covered services available before the child is discharged from the hospital are explained in more detail in the health plan provider manuals.
- Once a child is discharged from the initial hospital admission, the child receives Medicaid or traditional CHIP depending on their income. A full list of covered benefits is available at
- https://www.hhs.texas.gov/services/health/medicaid-chip/provider-information/texas-medicaid-chip-chip-perinatal-coverage/chip-perinatal-faqs

CHIP Perinatal Services Continued…

Reimbursement

- Women with CHIP perinatal coverage who have income at or below 198% of the FPL no longer need to apply for Medicaid at the time of delivery to cover their hospital stay. Instead, the hospital will need to fill out and send HHSC the mother's bar-coded Emergency Medical Services Certification (Form H3038). This form asks for the dates the woman received emergency medical services (labor with delivery). Once HHSC receives the completed Form H3038, Emergency Medicaid coverage will be established for the mother for the period of time reflected on the form.
- In these situations, facility charges are billed to TMHP. All professional charges are always billed to the CHIP perinatal health plan.

Please find a Copy of the H3038 Form at www.hhsc.state.tx.us*

CHIP Perinatal Services Continued…

- A CHIP perinatal provider can be an obstetrician/gynecologist (OB/GYN), a family practice doctor or another qualified health care provider that provides prenatal care.
- Covered services for CHIP Perinate Members must meet the CHIP Perinatal definition of "Medically Necessary.“

- ***Please refer to the Aetna Better Health Provider Manual (located on our website) for complete information on CHIP Perinate and CHIP Perinate Newborn Covered Services***

The Texas Vaccines for Children Program (TVFC) – Medicaid and CHIP

Texas leads the nation in the number of uninsured and underinsured children. The TVFC program helps to ensure that our children receive the complete series of immunizations required to protect them from vaccine-preventable diseases.

- Benefits of Participation
  - The TVFC program allows at-risk children to more easily access immunizations
  - The program eliminates the financial barriers to full immunization
  - Children receive vaccines from their PCP and other "medical home" providers

- Enrollment and participation is easy
  - More program information and an enrollment application can be found at: http://www.dshs.state.tx.us/immunize/tvfc/default.shtm.

ImmTrac – the Texas Vaccine Registry

- *ImmTrac* is an important component of Texas' strategy to improve vaccine coverage rates.
- The *ImmTrac* Registry serves to consolidate immunization records from multiple sources into a single registry
- Texas law states that health care providers must report to ***ImmTrac*** all vaccines administered to a child under 18 years of age within 30 days of administration.
- *ImmTrac* allows providers Internet access to immunization histories on and also supports reminder and recall capability.
- *ImmTrac* is available free of charge to authorized health care providers.

More information about the Texas Immunization Registry is available at http://www.dshs.state.tx.us/immunize/providers.shtm.

Preventive Health Care – STAR, CHIP & STAR Kids

- **STAR & STAR Kids**
  - Texas Health Steps (THSteps) – use periodicity schedule in provider manual for members ages 0 – 20
  - Medicaid members 21 and older – uses the U.S. Preventive Services Task Force, American Cancer Society and CDC recommendations published in the provider manual
- **CHIP**
  - Well child visits - use the American Academy of Pediatrics preventive health guidelines

Texas Health Steps (THSteps) - Medicaid

- Also known as the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) services
- Eligibility includes Medicaid recipients from birth to age 21
- Members may see any THSteps provider (self-referral)
- Covered services:
  - Periodic comprehensive physical examinations
  - Periodic dental checkups
  - Hearing and vision screening
  - Immunizations and lab work
  - Case management

THSteps Complete Checkup - Medicaid

- Document all components of the checkup that were performed during the visit. Please refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for a list of the necessary elements that make up a complete check-up. The TMPPM can be found on the TMHP website at www.tmhp.com.
  - Patients' medical records need to support diagnosis and procedures billed
  - Charts are subject to review for claims and quality of care
- Billing for THSteps checkup
  - Only complete medical checkups will be considered for reimbursement under the Medicaid managed care program
  - All components of the checkup are included in the reimbursement code for the comprehensive medical exam *(Refer to the Texas Medicaid Provider Procedures Manual for the correct billing codes)*
  - A provider must bill for THSteps services in accordance with state standards

THSteps Immunizations - Medicaid

- Immunizations and medical checkup should be administered according to the periodicity schedule. An updated periodicity schedule is available via the Aetna Better Health Provider Manual which can be found on the ABH website at www.aetnabetterhealth.com/texas
- Vaccines are supplied free of charge to THSteps providers for Medicaid clients
  - Call 1-800 SHOTS 4 U (1-800-746-8748)
  - www.immunizetexas.org
- Report immunization data to
  - www.ImmTrac.com or call 1-800-348-9158

Missed Appointments

- There maybe times where our members may miss an appointment.
- As a valued provider, if you find that a member is missing a number of appointments or cancellations you may utilize the Texas Health Steps Provider Outreach form https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/health-services-providers/thsteps/ths-provider-outreach-referral-form.pdf
- Phone number- 877.847.8377
- Fax number- 512.533.3867

Oral Evaluation and Fluoride Varnish - Medicaid

- THSteps providers can become certified by the Department of State Health Services to provide oral evaluation fluoride varnish
- For certification requirements, please access www.dshs.state.tx.us/thsteps
- THSteps providers can bill for oral evaluation fluoride varnish when performed on the same day as the THSteps medical checkup

THSteps Alberto N., ET AL. v Don A. Gilbert, ET AL. - Medicaid

- HHSC has settled a lawsuit that affects Texas Health Steps, Comprehensive Care Program-eligible children under 21 years of age. The terms of the settlement apply to Medicaid-funded nursing services, personal care services, therapy services and durable medical equipment and supplies.
  - https://hhs.texas.gov/sites/default/files/documents/laws-regulations/legal-information/alberto-n-settlement-agreement.pdf
  - One of the comprehensive assessments mandated in the 2005 settlement agreement, state staff began assessing individuals seeking or currently receiving Personal Care Services.
- Today the implementation of these new assessment tools helped standardize the assessment process. In addition the data collected helps to provide a full picture of the day-to-day assistance needed with children.

THSteps Alberto N., ET AL. v Don A. Gilbert, ET AL. - Medicaid

- We report on the nature and timing of services provided to children with an intellectual disability (ID) identified by a comprehensive assessment and care planning tool used to evaluate children's needs for Medicaid Personal Care Services (PCS).

THSteps and the Frew Settlement - Medicaid

- Frew vs Smith-- a lawsuit filed against the state, on behalf of children in the Texas Medicaid program, alleging these clients were unable to access appropriate healthcare services based on the federally mandated Early and Periodic Screening and Diagnostic Treatment (EPSDT) benefit for children under age 21.
- Results of settlement
  - Enhanced rates for pediatricians and subspecialists, such as neurologists
  - Investments that will enhance medical care for children in rural and inner urban areas
  - Improved state call centers to help Medicaid patients better understand treatment options
- For more information, please refer to www.aetnabetterhealth.com/texas

THSteps and Frew (continued)…

What does the Frew settlement agreement mean for providers?

- Increased fees for the provision of services
- Provide a complete checkup within 90 days of patient's enrollment in a Medicaid HMO and educate patient's parent or guardian regarding the benefits of preventive healthcare
- Ensure provision of medical and dental checkups according to periodicity schedule
- Document complete checkups and patient refusal of services
- Provide accelerated services to children of migrant farmworkers
- Cooperate with compliance monitoring of medical records documentation

THSteps and Frew (continued)…

Your responsibility as the child's provider

- Educate the child's parent or guardian regarding the health benefits of preventive care
- Schedule complete checkups in a timely manner according to the periodicity schedule
- Perform complete exam and document all components of THSteps exam within 90 days of member enrollment
- Perform timely complete exam and document all components of THSteps exam according to periodicity schedule
- Cooperate with compliance monitoring of medical records documentation

THSteps and Farm Worker Children (FWC) - Medicaid

Does your child travel with you when you leave home to do this work? We want your child to get the health care services he or she needs. We can help you make a Texas Health Steps checkup appointment. We want to help you get services for your children before you travel.

Please call 1-800-327-0016 to get more information.

- Farm Worker Children who are due for a THSteps medical checkup may receive their checkup on an accelerated basis before leaving the area
- Please allow these Farm Worker Children to obtain THSteps services expeditiously
- Performing a make-up exam for a late THSteps medical checkup is not considered an accelerated service; it is considered a “late checkup”

Quality Assessment and Performance Improvement – STAR, CHIP & STAR Kids

- Aetna Better Health Plan has an ongoing Quality Assessment and Performance Improvement (QAPI) Program that is comprehensive in scope, including both the quality of clinical care and service for all aspects of our health care delivery system. The ABH QAPI program is:
  - Tailored to the unique needs of the membership in terms of age groups, disease categories and special risk status.
  - Compliant with all State and federal requirements for Quality Improvement (QI).
  - Directed by a multidisciplinary committee whose members bring a diversity of knowledge and skills to the design, oversight, and evaluation of the program.

Cultural Competency – STAR, CHIP & STAR Kids

- Effective health communication is as important to health care as clinical skill. To improve individual health and build healthy communities, health care providers need to recognize and address the unique culture, language and health literacy of diverse consumers and communities. The Aetna Better Health Cultural competency program is geared toward:
  - **Improving health care access and utilization**
  - **Enhancing the quality of services within culturally diverse and underserved communities**
  - **Promoting cultural and linguistic competence as essential approaches in the elimination of health disparities.**

- Additional provider-focused Cultural Competency resources can be found on the U.S. Department of Health and Human Services (HRSA) website at: http://www.hrsa.gov/culturalcompetence/index.html

Member Rights & Responsibilities

- It is our policy not to discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law. Please review the list of member rights and responsibilities in the Provider Manual. Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity.
-
- In the event that we are made aware of an issue with a member not receiving the rights as identified above, we will initiate an investigation into the matter and report the findings to the Quality Management Committee and further action may be necessary.
- For a complete list of member's right and responsibilities, please review the Provider Manual.

Americans with Disabilities Act (ADA)

- The ADA gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications.

- Our providers are obligated to provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities (e.g., physical locations, waiting areas, examination space, furniture, bathroom facilities, and diagnostic equipment must be accessible)
- Offer waiting room and exam room furniture must meet needs the needs of all members, including those with physical and non-physical disabilities.
- Be accessible along public transportation routes and/or provides enough parking.
- Have clear signage and “way” finding (e.g., color and symbol signage) throughout doctors offices/facilities.

- Resources:
- http://www.ada.gov/reg3a.html

Access to Care Standards & Availability

Primary Care Providers provide covered services in their offices during normal business hours and are available and accessible to Members, including telephone access, 24-hours-a-day, 7 days per week, to advise Members requiring urgent or emergency services. If the Primary Care Provider is unavailable after hours or due to vacation, illness, or leave of absence, appropriate coverage with other participating physicians must be arranged.

If a member is referred to another Primary Care Provider who is not on record as a covering provider, a referral must be submitted to the Aetna Better Health Prior Authorization unit to prevent a delay in payment.

- PCP's must be accessible to Covered Persons 24 hours a day, 7 days a week, via one of the following methods:

(1) office phone answered by answering service, with calls returned by PCP within 30 minutes;

(2) office phone answered by recording in each language of the major population groups served by the PCP, with a recording giving the PCP's or another Participating Provider's direct number, which must be answered (referring the Covered Person to another recording is not acceptable);

(3) office phone transferred to another location that answers and contacts the PCP or another designated Participating Provider, with the call to be returned within 30 minutes. PCP's may not have a phone message that directs the Covered Person to simply leave a message or to go to the emergency room for any service needed, although direction to go to the emergency room for Emergency Care is appropriate.

Access to Care Guidelines

OBGYN/Prenatal Care

Level/Type of Care	Time to Treatment (Calendar Days)	Threshold
Low-Risk Pregnancies	Within 14 calendar days	85%
High-Risk Pregnancies	Within 5 calendar days	51%
New Members in the Third Trimester	Within 5 calendar days	51%

Access to Care Guidelines

Vision Care Threshold

Level/Type of Care	Standard	Threshold
Specialist Physician Access: Ophthalmology, Therapeutic Optometry	Members must be allowed to have access without a PCP referral to eye Health Care Services from a Network specialist who is an ophthalmologist or therapeutic optometrist for non-surgical services.	99.0%

Access to Care Guidelines

Primary Care Provider Thresholds

Standard	STAR Child	STAR Adult	CHIP	STAR+PLUS
Preventive health services - within ninety (90) calendar days	99.0%	99.0%	99.0%	99.0%
Routine primary care - within fourteen (14) calendar days	99.0%	95.8%	90.7%	87.2%
Urgent care - within twenty-four (24) hours	99.0%	99.0%	99.0%	99.0%

Access to Care Guidelines

Behavioral Health Thresholds

Standard	STAR Child	STAR Adult	CHIP	STAR+ PLUS
Initial outpatient behavioral health visit (child and adult within fourteen (14) calendar days	75%	79%	83%	89%

Access and Availability Requirements

- All Participating Providers must make Covered Services available and accessible to Covered Persons during normal business hours. All Participating Providers must provide telephone access to Covered Persons 24 hours a day, 7 days per week, regarding urgent or Emergency Care questions, and must meet the following standards:

Service	Standard
Referrals	Routine Specialist care referrals must be provided within 30 calendar days of the referral
After-hours	Coverage must be available after normal posted business hours 7 days a week, 365 days a year
After-hours calls returned	≤ 30 minutes
In-office wait time	≤ 30 minutes

Provider Appointment Standards

Provider Type	Emergency Services	Urgent Care	Non-Urgent	Routine Care	Wait Time in Office Standard
Primary Care Provider (PCP)	Same day	Within 24 hours	Within 72 hours	Within 14 days	No more than 30 minutes
Specialty Referral	Within 24 hours	Within 24 hours of referral	Within 72 hours	Within 4 weeks	No more than 30 minutes
Dental Care	Within 48 hours (2)	Within 3 days of referral		Within 30 days of referral	No more than 45 minutes
Mental Health/ Substance Abuse (MH/SA)	Same day	Within 24 hours		Within 14 days	No more than 45 minutes
Lab and Radiology Services	N/A	Within 48 hours	N/A	Within 3 weeks	N/A

Provider Appointment Standards Cont.

Physicals:	
Baseline Physicals for New Adult Members:	Within 180 calendar days of initial enrollment.
Baseline Physicals for New Children Members and Adult Clients of DDD:	Within 90 days of initial enrollment, or in accordance with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines.
Routine Physicals:	Within 4 weeks for routine physicals needed for school, camp, work, or similar.

Provider Appointment Standards Cont.

Prenatal Care: Members shall be seen within the following timeframes:
3 weeks of a positive pregnancy test (home or laboratory)
3 days of identification of high-risk
7 days of request in first and second trimester
3 days of first request in third trimester

HHSC Mandated Appointment Standards

Level/Type of Care	Time to Treatment (Calendar Days)
Low-Risk Pregnancies	Within 14 calendar days
High-Risk Pregnancies	Within 5 calendar days
New Members in the Third Trimester	Within 5 calendar days

Provider Appointment Standards Cont.

Initial:	
Initial Pediatric Appointments:	Within 3 months of enrollment
Supplemental Security Income (SSI) and Texas Care (ABD & Disabled Members):	Each new member will be contacted within 45 days of enrollment and offered an appointment date according to the needs of the member, except that each member who has been identified through the enrollment process as having special needs will be contacted within 10 business days of enrollment and offered an expedited appointment.

Maximum number of Intermediate/Limited Patient Encounters. 4 per hour for adults and 4 per hour for children.

After-Hours Coverage

- Primary Care Physicians must be accessible to members 24 hours a day, 7 days a week.
- The following are acceptable and unacceptable after-hours coverage.

After-Hours Coverage (Cont.)

Acceptable After-Hours Coverage:

- The office telephone is answered after hours by an answering service, which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned by a provider within 30 minutes.

- The office telephone is answered after normal business hours by language appropriate recording directing the patient to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the covering provider's phone. Another recording is not acceptable; and

- The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, or another designated medical provider, who can return the call within 30 minutes.

After-Hours Coverage (Cont.)

Unacceptable after-hours coverage:

- The office telephone is only answered during office hours;
- The office telephone is answered after hours by a recording, which tells the patients to leave a message;
- The office telephone is answered after hours by a recording which directs patients to go to an emergency room for any services needed; and
- Returning after-hours calls outside of 30 minutes.

Aetna Better Health Fraud and Abuse Policy – STAR, CHIP & STAR Kids

- Aetna Better Health (Aetna) recognizes its responsibility and commitment to detecting, preventing, investigating and reporting of waste, abuse, and fraud for all services pertaining to the Medicaid and CHIP programs, including services provided by subcontractors (vision services).

- Aetna Better Health also recognizes that it is responsible for investigating and reporting waste, abuse or fraud related to the filing of false claims against the United States Government or failure of an MCO to provide services required under contract with the state of Texas, enrollment/marketing violations and wrongful denial of claims.

- Aetna Better Health employees must adhere to the Corporate Code of Conduct to ensure ethical behavior and actions of all employees, and participate in annual training regarding corporate policies and procedures.

Fraud vs. Abuse

Fraud	Abuse
The intent to abuse the system. The intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit.	The misuse of the Medicaid and/or CHIP program without the intent to commit fraud. Business, medical or recipient practices that result in unnecessary reimbursement/cost to the program.

- Fraud and Abuse program overview is available in Aetna Better Health Provider Manual.
- Aetna Better Health Provider Manual is located at www.aetnabetterhealth.com/texas

What is waste?

- Less than fraud and less than abuse
- Involves practices that are not cost efficient such as ordering medical services or supplies beyond a patient's needs.

❖ Reporting Provider/Clients Waste, Abuse and Fraud is available in the Aetna Better Health Provider Manual.

❖ Aetna Better Health Provider Manual is located at www.aetnabetterhealth.com/texas

PROVIDER FRAUD, WASTE, AND ABUSE TRAINING

Welcome!

We designed this training to assist you in helping Aetna Better Health of Texas detect, report, and prevent fraud, waste, and abuse.

Following these requirements protects our members from harm and helps to keep health care costs down.

Definitions

Fraud: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Waste: over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

First you are require to comply with all applicable statutory, regulatory, including adopting and implementing an effective compliance program.

Second you have a duty to the program to report any violations of laws that you may be aware of.

Third you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

A provider's best practice for preventing fraud, waste, and abuse is to (also applies to laboratories as mandated by 42 CFR 493):

- Develop a compliance program
- Monitor claims for accuracy - ensure coding reflects services provided
- Monitor medical records – ensure documentation supports services rendered
- Perform regular internal audits
- Establish effective lines of communication with colleagues and members

Member Abuse and Neglect

IDENTIFYING & REPORTING ABUSE, NEGLECT & EXPLOITATION OF A MEMBER

Aetna Better Health's policy is to promote the education of network providers including long term care facilities on the identification and reporting of actual and suspected abuse, neglect, and exploitation of our members.

Definitions

Neglect means intentional or unintentional failure to fulfill a caregiver's obligation or duty to an elderly person. "Self neglect" can also occur when an elderly person is unable or unwilling to make provision for proper care for themselves.

Abuse constitutes the intentional infliction of physical harm, causing injury as a result of negligent acts or omissions, unreasonable confinement, sexual abuse, or sexual assault of an individual 18 years of age or older who is unable to protect himself or herself from abuse, neglect or exploitation by others because of a physical or mental impairment.

Aggravating circumstances (such as cruelty, recklessness, and malice in causing injury to others) are often considered by the courts in imposing more severe sentence than a typical sentence for similar offenses.

Neglect

Types of Neglect

- The intentional withholding of basic necessities and care
- Not providing basic necessities an care because of lack of experience, information , or ability

Signs of Neglect

- Malnutrition or dehydration
- Unkempt appearance; dirty or inadequate
- Untreated medical condition
- Unattended for long periods or having physical movements unduly restricted

Examples of Neglect

- Inadequate provision of food, clothing, or shelter
- Failure to attend health and personal care responsibilities, such as washing, dressing, and bodily functions

Abuse

Examples of Abuse

- Bruises (old and new)

Abuse, Neglect and Exploitation

Background:

In order to comply with existing MCO critical incident reporting requirements, the information outlined below must be collected from MCO's contracted providers of Medically Dependent Children Program (MDCP) services.

Action:

To meet federal requirements regarding critical incident reporting (see links to federal requirements for incident reporting in below 'Resources' section), **STAR Kids and STAR Health** MCOs must require their contracted providers of MDCP services to report to them all critical incidents, including Abuse, Neglect, and Exploitation (ANE).

MCOs must also require these providers to submit to the relevant MCO all Adult Protective Services (APS) investigation reports resulting in a confirmed case of ANE, along with a summary of any remediation taken in response. APS reports must be submitted to the MCO within one business day of receipt from APS.

This requirement is effective September 1, 2018, and the updates have now been made in the UMCM – see Resources below.

- **Uniform Managed Care Manual**
- **5.18 Critical Incidents and Abuse, Neglect, and Exploitation Quarterly Report**
- **5.18.1 & 5.18.2**

Reporting Waste, Abuse and Fraud by a Provider or Client – Medicaid & CHIP

Please contact the following:

Aetna Better Health
Attention: SIU Coordinator
PO Box 818042
Cleveland, OH 44181-8042
1-866-519-0916

- Provider manual is located on the Aetna website www.aetnabetterhealth.com/texas
- Fraud and Abuse reporting information is found on page 124 on the provider manual.

To report providers:

Office of Inspector General
Medicaid Provider Integrity/Mail Code 1361
PO Box 85200
Austin, TX 78708-5200

To report clients:

Office of Inspector General
General Investigations/Mail Code 1362
PO Box 85200
Austin, TX 78708-5200

- If you do not have internet access, call the HHSC Office of Inspector General Fraud Hotline at 1-800-436-6184.

Fraud, Waste & Abuse

Do you want to report Waste, Abuse, or Fraud?

- Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

  - Getting paid for services that weren't given or necessary.
  - Not telling the truth about a medical condition to get medical treatment.
  - Letting someone else use their Medicaid ID.
  - Using someone else's Medicaid or CHIP ID.
  - Not telling the truth about the amount of money or resources he or she has to get benefits.

Fraud, Waste & Abuse cont'd

To report waste, abuse or fraud, choose one of the following:

- Call the OIG Hotline at **1-800-436-6184**;
- Visit **https://oig.hhsc.state.tx.us**/ Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:
- Aetna Better Health of Texas
- 750 W. John Carpenter FWY Irving, TX 75039

Fraud, Waste & Abuse cont'd

To report waste, abuse or fraud, gather as much information as possible.

When reporting about a provider (a doctor, dentist, counselor, etc.) include:

- Name, address, and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

When reporting about someone who gets benefits, include:

- The person's name
- The person's date of birth, Social Security number, or case number if you have it
- The city where the person lives
- Specific details about the waste, abuse, or fraud

Provider Complaints, Grievance & Appeals

Provider Payment Disputes:

- Network providers may file a payment dispute verbally or in writing direct to Aetna Better Health of Texas to resolve billing, payment and other administrative disputes.

Provider Complaints:

- Both network and out-of-network providers may file a verbal complaint with Aetna Better Health of Texas. Provider complaints are an expression of dissatisfaction filed with Aetna Better Health of Texas that can be resolved outside of the formal appeal and grievance process.

Provider Grievances:

- Both network and out-of-network providers may file a formal grievance in writing directly with Aetna Better Health of Texas in regard to our policies, procedures or any aspect of our administrative functions including dissatisfaction with the resolution of a payment dispute or provider complaint that is not requesting review of an action.

Provider Appeal:

- A provider may file a formal appeal in writing, a formal request to reconsider a decision (e.g., utilization review recommendation, administrative action), with Aetna Better Health of Texas within 90 calendar days from the Aetna Better Health of Texas Notice of Action.

Medical Records - Standards

Laws, rules, and regulations require that network providers retain and make available all records pertaining to any aspect of services furnished to a members or their contract with Aetna Better Health of Texas for inspection, evaluation, and audit for the longer of:

- A period of 5 years from the date of service; or 3 years after final payment is made under the provider contract/subcontract and all pending matters are closed.

Additional Information:

- Providers must maintain member records in either a paper or electronic format.
- Providers must also comply with HIPAA security and confidentiality of records standards.

Our standards for medical records have been adopted from NCQA and the Medicaid Managed Care Quality Assurance Reform Initiative (QARI). For a complete list of minimum acceptable standards, please review the Provider Manual.

Additional Information & Important Requirements

- Providers may not refuse treatment to qualified individuals with disabilities, including but not limited to individuals with the Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

- Accommodating members with special needs, which includes but is not limited to: offering extend office hours to include night and weekend appointments, promoting practices offering extended hours, and offering flexible appointment scheduling systems

- Ensuring that hours of operation are convenient to, and do not discriminate against, members. This includes offering hours of operation that are no less than those for non-members, commercially insured or public fee-for-service individuals (e.g. hours of operation may be no less than those for commercially insured or public fee-for-service insured individuals) All services are available 24 hours a day, 7 days a week when medically necessary

Maintaining Contact Information

- Network providers must inform Aetna Better Health of demographic changes by emailing: ABHTXCredentialing@aetna.com

Update us on any changes to your address, telephone number, group affiliation and/or any other relevant contact information for the purposes of:

- The production of an accurate provider directory
- The support of an accurate online provider lookup function
- The ability to contact you or your office with requests for additional information for prior authorization or other medical purposes, or on behalf of a member's PCP
- The guarantee of accurate claim payment delivery information

Provider Services Call Center

- Medicaid STAR **1-800-248-7767** (Bexar) **1-800-306-8612** (Tarrant)
  - Medicaid STAR Kids **1-844-STRKIDS** (**1-844-787-5437**) Tarrant
  - Medicaid STAR Kids 1-XXX-XXX-XXXX Dallas
  - CHIP or CHIP Perinate **1-866-818-0959** (Bexar), **1-800-245-5380** (Tarrant)

Aetna Better Health Medicaid, CHIP and STAR Kids
www.aetnabetterhealth.com/texas

- Provider manuals
- https://www.aetnabetterhealth.com/texas/assets/pdf/provider/Provider%20Manual_2015_TX-12-08-06_0915_FINAL.pdf
- https://www.aetnabetterhealth.com/texas/assets/pdf/provider/STARKids-ProviderManual.pdf

- Provider directory/Provider search
- Member handbook

- Member eligibility with Aetna Medicaid or CHIP

- Links to subcontractors (Superior Vision)

- Complaints and appeals process

New Provider Orientation - Handouts

- Medical Record Criteria
- ABH Provider Newsletter
- Member Acknowledgement Form
- Private Pay Agreement
- ABH Demographic Form
- ABH Prior Authorization List
- TX Standard Prior Authorization Form
- Evicore/Med Solutions
- Provider Claims Appeal Form
- Claims Appeal process
- Complaint Form
- Texas Health Steps QRG
- THS Screening Updates
- After Hours Access Survey standards
- Aetna Behavioral Health services
- THS Outpatient Lab Services
- ICD 10 FAQ
- ABH Provider Advisory Committee
- Sport Physicals
- ABH Important Phone Numbers
- Emdeon Virtual Card Payment Notice
- Helpful resource links
- Billing information
- HHA/DME Medical Supplies Form
- Farm Worker Children (FWC)
- Availability & Accessibility
- Provider Complaints & Appeals
- THS Periodicity Schedule
- Medicaid Benefits FAQ

These handouts will be mailed separately!!!

Please send an email NOW !!! to: PRAssistance@Aetna.com

On the subject line of the email, enter your Webinar Presenter's name.

In the email please include the below information

Please include in the body of the email:

- ❑Attendee Name(s), Ph#,
- ❑Facility Name, Provider NPI# and Tax ID #
- ❑Date you completed the Webinar
- ❑Any questions you may have that require follow up
- ❑An Orientation Training Sign in Sheet, PR Visit Record with a survey will be emailed to you to complete and return to the health plan. A copy of the NPO slide deck will be emailed to you as well

The requested email to us is to confirm your attendance to this required training and to provide validation to HHSC that New Provider training was completed.


Thank You
aetna