Provider Manual

2023/2024

aetna®

Aetna Better Health® of West Virginia

WV-23-11-01

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Chapter 1 – Welcome to Aetna Better Health

We're pleased that you are part of our network. At Aetna Better Health, we're committed to providing accessible, high-quality service to our members in West Virginia. And we greatly appreciate all our practitioners' and providers' efforts in helping us achieve that goal.

To ensure that we communicate effectively with practitioners and providers, we've developed this Provider Manual. This document will help guide practitioners and providers through our administrative processes. As changes occur, we'll continue to update practitioners and providers with letters, the website, webinars, forums and regular contact with provider relations representatives.

Thank you for your participation and interest in caring for our members.

About Us

Aetna Better Health has been a leader in Medicaid managed care since 1986 and currently serves more than 2.3 million people in 16 states. Aetna Better Health and its affiliates currently own plans and administer Medicaid services in Arizona, California, Florida, Illinois, Kansas, Kentucky, Louisiana, Maryland, Michigan, New Jersey, New York, Ohio, Pennsylvania, Texas, Virginia and West Virginia. Aetna Better Health also provides Medicaid-related administrative services to New Hampshire's Medicaid Program.

Aetna Better Health has more than 30 years of experience in managing the care of the most medically vulnerable, using innovative approaches to achieve successful health care results.

Aetna Better Health has two programs: The Mountain Health Trust (MHT) program is the West Virginia managed care program for enrollees who meet the requirements to be eligible for either the TANF, ACA, SSI or CHIP program. The Mountain Health Promise (MHP) is the West Virginia Medicaid managed care program for enrollees who are in foster care or are receiving adoption assistance, and those children eligible under the Serious Emotional Disorder (SED) Home and Community Based Services (HCBS) waiver program.

Model of Care

Our model of care offers an integrated care management approach. This means enhanced assessment and management for enrolled members. The processes, oversight committees, practitioner/provider collaboration, care management and coordination efforts applied to address enrollee needs result in a comprehensive and integrated plan of care for members.

Our combined practitioner/provider and care management activities are intended to improve quality of life, health status, and appropriate treatment. Specific goals of the programs include:

- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve seamless transitions of care across healthcare settings and practitioners/providers
- Promote appropriate utilization of services and cost-effective service delivery

Our efforts to promote cost-effective health service delivery include, but are not limited to the following:

- Review of network for adequacy and resolve unmet network needs
- Clinical reviews and proactive discharge planning activities
- An integrated care management program that includes comprehensive assessments, transition management, and provision of information directed towards prevention of complications and preventive care services

Many components of our integrated care management program influence member health. These include:

- Comprehensive member health assessment, clinical review, proactive discharge planning, transition management, and education directed towards obtaining preventive care. These care management elements are intended to reduce avoidable hospitalization and nursing facility placements/stays.
- Identification of individualized care needs and authorization of required home care services/assistive equipment when appropriate. This is intended to promote improved mobility and functional status and allow enrollees to reside in the least restrictive environment possible.
- Assessments and care plans that identify an enrollee's personal needs, which are used to direct education efforts that prevent medical complications and promote active involvement in personal health management.
- Care Manager referral and predictive modeling software that identify enrollees at increased risk, functional decline, hospitalization, and emergency department visits.

Service Area

Our service areas include all cities and counties in West Virginia.

About This Manual

This manual serves as a resource to practitioners/providers and outlines operations for Aetna Better Health of West Virginia. Through the manual, practitioners and providers should be able to identify information on the majority of issues that may affect working with Aetna Better Health. Questions, problems, or concerns that the manual doesn't fully address can be directed to the Provider Services department at **1-888-348-2922**. Additional information for practitioners, providers and members is available online at: **AetnaBetterHealth.com/WestVirginia**. A current copy of the Provider Manual is kept on this website. To navigate to the provider manual, click on "Provider Site" in the header and then click on "Provider Manual" under the Helpful Links section.

References throughout the manual to "Aetna," the "health plan," or Aetna Better Health are intended to represent Aetna Better Health.

Chapter 2 – Contacts

Our standard business hours are Monday -- Friday from 8:30 AM to 5PM, Eastern Standard Time. Member Services is available 24 hours a day, 7 days a week.
Our office is closed on these holidays:

New Year's Day
Martin Luther King Jr. Day
Memorial Day
Independence Day
Labor Day
Thanksgiving Day
Christmas Day

Important phone numbers

Aetna Better Health	Toll-free	Fax
Provider Services (Claims Inquiry and Claims Research, CICR)	**1-888-348-2922**	
Member Services	**1-888-348-2922**	**1-866-669-2454**
Prior Authorization	**1-844-835-4930**	**1-866-366-7008**
Provider Relations	**1-888-348-2922**	**1-866-810-8476**
Behavioral Health Services	**1-888-348-2922**	
Appeals	**1-888-348-2922**	**1-888-388-1752**
Care Management/Chronic Condition Management	**1-888-348-2922**	**1-866-261-0581**

Important addresses

Department	Address
Claims	Electronic Payer ID: 128WV **Aetna Better Health of West Virginia** P.O. Box 982965 El Paso, TX 79998-2965
Appeals	**Aetna Better Health of West Virginia** Attn: Appeals Coordinator PO Box 81040 5801 Postal Rd Cleveland, OH 44181

Websites

In addition to the telephone numbers and addresses above, participating practitioners and providers may access the Aetna Better Health website 24 hours a day, 7 days a week at: **AetnaBetterHealth.com/WestVirginia** for up-to-date information, forms, and other resources.

Within the website, a secure web portal is maintained; the web portal can be accessed directly at **AetnaBetterHealth.com/WestVirginia**. The secure web portal provides a platform for Aetna Better Health to communicate health care information directly to practitioners and providers. The health plan's eligibility and claims information can be accessed via the web portal. Additional information regarding the website and secure web portal is available in the Provider Services chapter.

We have a voice response system available to practitioners and providers 24 hours a day, 7 days a week to check member eligibility and the status of a claim. Practitioners and Providers may access this system by calling **1-888-348-2922**. Practitioners and Providers also have access to our website at **AetnaBetterHealth.com/WestVirginia.**

General information regarding the Department of Health and Human Services West Virginia Medicaid Program, The Bureau for Medical Services and WV CHIP can be found online at **dhhr.wv.gov**. The West Virginia Medicaid Program provider manual can be found at **dhhr.wv.gov/bms/Pages/Manuals.aspx .**

Topics	For additional information
Information	**www.wvmmis.com** **www.dhhr.wv.gov/bms/Medden/Pages/default.aspx** Toll Free: **1-304-348-3360** or **1-888-483-0793**
Bulletins	**www.dhhr.wv.gov/bms/BMSPUB/Pages/default.aspx**
Enrollment	**www.wvmmis.com/default.aspx** Phone: **1-888-483-0793**, Option 3
West Virginia Medicaid/CHIP Eligibility	**www.wvmmis.com** Phone: **1-888-483-0793**
Adult and Child Abuse & Neglect Hotline	**www.dhhr.wv.gov/bcf/Services/Pages/Centralized-Intake-for-Abuse-and-Neglect.aspx**

Reporting Suspected Fraud and Abuse

Participating practitioners and providers are required to report to Aetna Better Health and to the State of West Virginia all cases of suspected fraud and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid or CHIP programs.

Practitioners and providers can report suspected fraud or abuse to Aetna Better Health in the following ways:

- Write us:
  Aetna Better Health
  Attn: Special Investigations Unit
  500 Virginia Street, East, Suite 400
  Charleston, WV 25301

- Call Aetna Better Health's Fraud, Waste and Abuse toll-free number at **1-844-405-2016**.

Chapter 3 – Provider Services Department

The Provider Services department serves as a liaison between Aetna Better Health and the practitioner and provider community. This department also supports network development and contracting with multiple functions, including the evaluation of the network and compliance with regulatory network capacity standards. Provider Services includes: Claims Inquiry and Claims Research (CICR) and Provider Relations.

Claims Inquiry and Claims Research (CICR)

CICR Representatives are available by phone to provide telephonic or electronic support to all practitioners and providers. Below are some of the areas where Claims Inquiry and Claims Research provide assistance:

- Claims questions, inquiries, and disputes
- Review claims or remittance advice information
- Highlight recent updates
- Locate forms
- Prior authorization inquiries
- Reports of suspected fraud, waste or abuse

Claims Inquiry and Claims Research can be reached at **1-888-348-2922**.

Provider Relations

Provider Relations assists practitioners and providers by providing education and assistance regarding a variety of topics.
Provider Relations will:

- Be a point of contact for any practitioner or provider concern• Provide education to practitioner and provider offices
- Provide support on Aetna Better Health policies and procedures
- Clarify contract provisions
- Assist with demographic changes, terminations, and initiation of credentialing
- Monitor compliance with applicable State and Federal agencies
- Conduct an annual Practitioner and Provider Satisfaction Survey
- Conduct member complaint investigation
- Maintain the practitioner/provider directory
- Assist practices to obtain secure web portal or member care login information

The Provider Relations department is responsible for the ongoing education and training of Aetna Better Health's practitioner and provider community. We maintain a strong commitment to meeting the needs of our practitioners and providers. In order to accomplish this, a provider relations representative is assigned to specific groups of participating practitioners and providers. This process allows each office to become familiar with its representative and form a solid working relationship. Each provider representative has a thorough understanding of our health plan operations and is well versed in the managed care program.

A provider relations representative will visit or phone practitioner and provider offices periodically to ensure their experiences with us are seamless. Representatives meet routinely with office staff and practitioners or providers and are available upon request. News, electronic messages, and specialized mailings are sent to practitioners and providers periodically that include updates to the manual, changes in policies or benefits, and general news or information of interest to our practitioner and provider community. To contact a local provider relations representative, please call **1-888-348-2922**.

Joining the Network

Practitioners and Providers interested in joining the Aetna Better Health's network should contact Provider Relations at **1-888-348-2922** for additional information regarding contracting and credentialing.

Practitioner/Provider Orientation

We provide initial orientation for newly contracted practitioners and providers after joining our network. In follow up to initial orientation, we provide a variety of forums for ongoing training and education, such as routine site visits, group or individualized training sessions on select topics (i.e. enrollee benefits, Aetna Better Health website navigation), distribution of bulletins containing updates and reminders, and online resources through our website at **AetnaBetterHealth.com/WestVirginia**.

News and other communications

We regularly publish practitioner and provider updates on our website and our provider portal. This is the main source of mass communication to participating practitioners and providers. Our website is located at **AetnaBetterHealth.com/WestVirginia**. The updates may include Provider Manual amendments. The Provider Manual amendments are part of the practitioner or provider's contract.

Provider Contract and Manual Updates

These updates are intended to explain amendments and keep participating practitioners and providers abreast of issues including, but not limited to programs, policy and procedure changes/updates, network changes, and changes in the Schedule of Allowances, billing information, and general topics of interest. These notices should be considered part of this manual and kept for further reference. News, announcements and contract amendments are posted on our website at **AetnaBetterHealth.com/WestVirginia** » Providers » Announcements and News.

Aetna Better Health also communicates regularly with its participating practitioners and providers by sending broadcast emails and faxes. When there are program or service site changes, the notification of changes will be provided at least 30 calendar days before the intended effective date of the change. Please be sure to contact your Provider Relations representative immediately if you change your email address or fax number to ensure proper receipt.

Chapter 4 – Practitioner/Provider Responsibilities and Important Information

This section outlines general practitioner and provider responsibilities; additional responsibilities are included throughout the manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Practitioners and providers are contractually obligated to adhere to and comply with the terms of the West Virginia Medicaid and CHIP Programs, participation contract, and requirements in this manual. Aetna Better Health may or may not specifically communicate such terms in forms other than the participation contract and this manual.

Practitioners and providers must act lawfully in the scope of practice or treatment, management, and discussion of the medically necessary care and advising or advocating appropriate medical care with or on behalf of a member, including providing information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered including all relevant risk, benefits and consequences of non-treatment. Advice given to potential or enrolled members should always be given in the best interest of the member.

State of West Virginia Enrollment

Practitioners or providers who provide services to our members must be enrolled as a West Virginia Medicaid and/or CHIP practitioner or provider at each practice location with the State of West Virginia and credentialed by Aetna Better Health before they can provide health care to our members. To access enrollment information for the State of West Virginia, please refer to the department's website at: **www.wvmmis.com** or phone: **1-888-483-0493** or **304-348-3360.**

Aetna Better Health does not provide gifts to providers for the purpose of distributing them directly to the MCO's potential members or currently enrolled members; conduct potential member orientation in common areas of providers' offices; allow providers to solicit enrollment or disenrollment in an MCO, or distribute MCO-specific materials at a Marketing activity (this does not apply to health fairs where providers do immunizations, blood pressure checks, etc. as long as the provider is not soliciting enrollment or distributing plan specific MCO materials); or assist with MCO enrollment forms. This includes using social media as a means to post or send protected private information, advertise via direct communication with potential members, directly respond to any members for anything other than a general response (such as MCO phone number or website links), partake in individual communication, request or add followers or friends, tag individuals.

National Provider Identifier (NPI) Number

The National Provider Identifier (NPI) number is a 10-digit number that is practitioner or provider specific assigned by CMS. For additional information please visit the National Plan/Provider Enumeration System (NPPES) website at: **https://nppes.cms.hhs.gov/**. NPI numbers are required for claims submission to Aetna Better Health. The CMS 1500 and UB04 claim forms contain fields specifically for the NPI information. On the CMS 1500 form the rendering practitioner's or provider's (box 31) NPI number is placed in the bottom half of the 24 J fields. The NPI for the billing practitioner or provider in box 33 is placed in the 33A field.

Access and Availability Standards

We utilize accessibility/availability standards based on requirements from NCQA, State and Federal regulations. The Access Standards are communicated to practitioners, providers and members through the Aetna Better Health's website, and as part of the Provider Manual. Federal law requires that participating practitioners and providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to members not enrolled in Medicaid or CHIP. If the practitioner or provider serves only Medicaid and/or CHIP recipients, hours offered to Aetna Better Health managed care members must be comparable to those for Medicaid and CHIP fee-for-service members. Practitioners and providers that do not meet Aetna Better Health's access standards are provided recommendations for improvements in order to meet the set standard.

Timely access		
Timely access-standards for hours of operation for PCP's: General appointment accessibility - twenty hours per week per practice location		
Practitioner type	**Appointment type**	**Accessibility standard**
Primary Care	Regular/Routine PCP (non-urgent)	Within 21 calendar days
	EPSDT Service	Scheduled in accordance with EPSDT guidelines and periodicity schedule within 30 days
	Urgent Care	Within 48 hours
	Emergency Care	Immediately or referred to ER facility
	After-hours Care (PCP)*	24 hours day/ 7 days per week
Prenatal Care	Initial Prenatal appointment	Within 14 calendar days of pregnancy confirmation
Specialty Care	New patient initial appointment	Within 90 calendar days
	Existing patient follow up	Within 30 calendar days
	Urgent Care Appointment (high volume and high impact	Within 48 hours
	Emergency Care Appointment (high volume and high impact	Seen immediately or referred to ER facility
Behavioral Health Care	Initial/Routine Care	Within 10 business days
	Routine/Follow-Up (non-urgent, symptomatic conditions)	Within 60 calendar days
	Emergency Care	Immediately or referred to ER
	Urgent Care (no immediate danger to self or others and/or if the situation is not addressed within 48 hours, it may escalate)	Within 48 hours
	Non-Life-Threatening Emergency (no immediate danger to self or others and/or if the situation is not addressed within 6 hours, it may escalate.)	Within 6 hours
	Discharge Follow-Up Visit	Within 7 calendar days of discharge

***Management of After-hours Access**

- Access to after-hours care by a network PCP is available to members 24 hours a day, 7 days a week. (Emergency Room practitioners and Urgent Care Centers are not considered "network practitioners for routine call duty").
- After-hours calls to the answering service for urgent problems are returned immediately.
- After-hours calls to the answering service for non-urgent problems are returned within 30 minutes.

We provide access to care 24 hours a day, 7 days a week. This benefit helps ensure overall quality and continuity of care and prevents inappropriate and inefficient use of emergency room facilities for routine, non-emergent care.

The PCP is responsible for directing a member's after-hours, holiday, and weekend care. The PCP may direct a patient to seek care at an emergency facility, give a recommendation, and prescribe treatments or medications until the member can visit the PCP office.

An Aetna Better Health member will access care after normal working hours by contacting his or her PCP. Members and contracted practitioners and providers are advised that the PCP is to return a call for authorization of services or direct a member's care within 30 minutes. In the event that the 30 minutes has elapsed, the facility or member can call our 24-Hour Nurse Line for assistance. Our 24-Hour Nurse Line, staffed by registered nurses, is available to members 24 hours a day, 7 days a week, including holidays, at **1-855-200-5975**. Our Nurse Line will provide advice regarding services such as seeking emergency care, specific health concerns, and other services needed after regular business hours.

Emergencies should be treated immediately. An emergent medical condition is where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in placing the individual's health or the health of an unborn child in immediate jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

Aetna Better Health members are informed that the PCP and Aetna Better Health must be notified of any emergency by the next business day to ensure payment. True emergency care does not require any advance notification to us prior to the delivery of services.

Every practitioner or provider participating in the Aetna Better Health network must understand the mutual responsibility which Aetna Better Health and the individual practitioner or provider have for providing emergency services.

Please note the following:

- After-hours care must be authorized by the next business day to ensure appropriate payment; and
- Members should be instructed to contact the PCP's office for any follow-up care after an ER visit (e.g., suture removal, dressing change, etc.)

Monitoring of Standards

Monitoring of network practitioner and provider access and availability will be completed to ensure that the sufficiency of its network will meet the health care needs of members for Primary Care Practitioners (PCPs), Behavioral Health practitioners, and specialists, as appropriate. To monitor compliance with the Access and Availability Standards the health plan will:

- Review, at least annually, results of the Geo-access reports, completed by utilizing industry-standard software, to monitor compliance with the Availability standards.
- Review the annual results of the Consumer Assessment of Health Plans Study (CAHPS), a member satisfaction survey, to monitor compliance with the Accessibility standards.
- Routinely monitor member complaints.
- Routinely monitor after-hour telephone accessibility through member complaints and member, practitioner and provider surveys or after-hours phone audits to ensure that the practitioner/provider or an associate is available 24 hours per day, 7 days per week.
- Announced and ad hoc site visits to the practitioners' and providers' office by Provider Relations Representative for any practices identified as meeting the threshold for member complaints.

Resolution of Deficiencies

- If a participating network practitioner or provider fails to meet access standards, the Provider Relations representative will contact the practitioner or provider to inform them of the deficiency, educate them regarding the standards and work to correct the barrier to care.
- If there is a serious breach of the participating network practitioners' or providers' commitment to members and non-compliance with access to care, the practitioner or provider may be required to submit a Corrective Action Plan (CAP) and will be monitored until the CAP enables them to be compliant.
- If any network deficiencies are identified through the quarterly Geo-access review, applications or requests for participation will be sent to non-contracted practitioners or providers in the affected service area(s).
- The health plan will also monitor and trend any member complaints regarding accessibility and availability of practitioners and providers by product. If trends are identified, the health plan will promptly begin the recruiting process.

Covering Practitioners

We must be notified of practitioners who serve as covering practitioners for any of our network practitioners. This notification must occur in advance of the provision of any authorized services. Reimbursement to a covering practitioner is based on West Virginia Medicaid or CHIP fee-for service rate schedule and dependent on enrollment as a practitioner with both Aetna Better Health and the State of West Virginia. Failure to notify Provider Services of covering practitioners may result in claim denials.

Use of Non-participating Practitioners/Providers

Unless otherwise prior authorized by Aetna Better Health, participating practitioners or providers must be utilized for services arranged or coordinated by participating practitioners or providers. Examples of these services are lab procedures, DME supplies, and use of assistant surgeons. If a participating practitioner or provider sends specimens to a nonparticipating practitioner or provider for interpretation, provides DME or supplies from a nonparticipating vendor, or uses the services of a nonparticipating assistant surgeon, the participating practitioner or provider will be held responsible for the nonparticipating practitioner's or provider's charges. In the event that a nonparticipating practitioner or provider is recommended, it is the responsibility of the participating or practitioner provider to obtain a prior authorization for these services. Prior to being held liable, you will receive written notification in the form of a Pay and Educate letter for the first offense. A copy of this letter is sent to Provider Relations for recruitment of the non-participating practitioner or provider. After the initial warning, it will be your responsibility to verify the practitioner's or provider's participation status.

Termination and Restrictions

Practitioners or providers wishing to terminate their participation must notify Aetna Better Health in writing. Please refer to your Participation Agreement for detailed requirements about the termination process.

Practitioners or providers who wish to restrict their practice in any way also must restrict their practice to all carriers and must give us written advance notification as stated in your Participation Agreement. The Participation Agreement has provisions regarding the necessary timing.

Participation Agreements will not be terminated by Aetna Better Health to a penalize practitioner or provider in the event practitioner or provider: (a) advocates in good faith on behalf of a member; (b) files a complaint against Aetna Better Health; (c) appeals a decision made by Aetna Better Health; (d) treats a substantial number of patients who require expensive or uncompensated care; or (e) requests an expedited appeals resolution or supports an enrollees appeal.

Ancillary Personnel Performing Services

For any health care professionals employed by, under contract with, or otherwise supervised by the practitioner or provider when such professionals are not required to be credentialed directly by Aetna Better Health, the practitioner or provider must implement peer review and credentialing of such health care professionals who provide covered services to members on behalf of, or under the supervision of, the practitioner or provider. These personnel are defined as:

- Nurse Practitioners (unless they are credentialed as a Primary Care Practitioner)
- Physician Assistants
- Certified Nurse Midwives
- Physical, Occupational and Speech Therapists, and
- Certified Registered Nurse Anesthetists (CRNAs).

Verifying Enrollee Eligibility

All practitioners and providers, regardless of contract status, must verify an enrollee's enrollment status prior to the delivery of non-emergent, covered services. Practitioners and providers are not reimbursed for services rendered to enrollees who lost eligibility. Practitioners and providers are expected to review the members' Medicaid ID card in addition to reviewing their Aetna Better Health of WV ID Card. Enrollee eligibility can be verified through one of the following ways:

- Website: **www.wvmmis.com**
- Aetna Better Health member eligibility provider portal: **AetnaBetterHealth.com/WestVirginia**.
- Aetna Better Health Member Services: **1-888-348-2922**

Secure Web Portal

The Secure Web Portal is a web-based platform that allows Aetna Better Health to communicate member healthcare information directly with practitioners and providers. Practitioners and providers can perform many functions within this web-based platform. The following information can be obtained from the Secure Web Portal:

- Member Eligibility – Verify current eligibility of members.
- Panel Roster – View the list of members currently assigned to the practitioner as the PCP.
- Practitioner/Provider List – Search for a specific practitioner or provider by name, specialty, or location.
- Claims Status Search – Search for claims by member, practitioner or provider, claim number, or service dates. only claims associated with the user's ID will be displayed.
- Remittance Advice Search – Search for claim payment information by check number, practitioner or provider, claim number, or check issue/service dates. Only remits associated with the user's account ID will be displayed.
- Authorization List – Search for authorizations by member, practitioner or provider, authorization data, or submission/service dates. Only authorizations associated with the user's account ID will be displayed.
- Submit Authorizations – Submit an authorization request on-line
- Healthcare Effectiveness Data and Information Set (HEDIS) – Check the status of the member's compliance with any of the HEDIS measures. A "Yes" means the enrollee has measures that they are not compliant with; a "No" means that the member has met the requirements.
- Secure messaging to various departments of Aetna Better Health

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website.

If you're interested in using this secure online tool, you can register on our "For Providers" page at **AetnaBetterHealth.com/WestVirginia**. You can also contact our Provider Services Department to sign up over the phone. To submit your registration via fax, you can download the form from our website or request a copy from Provider Services. Please note that Internet access and a valid email is required for registration.

Practitioner or Provider groups must first register a principal user known as the "Provider Representative." Once registered, the "Provider Representative" can add authorized users within each entity or practice. For instructions to add authorized users, go to **AetnaBetterHealth.com/WestVirginia** and select Secure Web Portal Navigation Guide.

Overview of Features for Members

Members can register for their own secure member portal accounts at **AetnaBetterHealth.com/WestVirginia**. We have customized the member portal to better meet their needs. Members will have access to:

- Health and Wellness Appraisal – This tool will allow members to self-report and track their healthy behaviors and overall physical and behavioral health. The results will provide a summary of the members overall risk and protective factors and allow the comparison of current results to previous results, if applicable. The health assessment can be completed annually and will be accessible in electronic and print formats.
- Educational resources and programs – members can access self-management tools for specific topics such as smoking cessation and weight management.
- Claim status – members and their practitioners or providers can follow a claim from the beginning to the end, including: current stage in the process, amount approved, paid, member cost (if applicable) and the date paid.

- Personalized health plan services information – Members can now request a member ID card, change PCPs and update their address through the web portal (address update is a feature available for members, practitioners and providers). Members can also obtain referral and information on authorization requirements; and they can find benefit and financial responsibility information for a specific service.
- Innovative services information – Members will be asked to complete a personal health record and complete an enrollment screening to see if they qualify for any chronic condition management or wellness programs.
- Nurse Line – The Nurse Line is available 24 hours a day, 7 days a week. Members can call or send a secure message to a registered nurse who can provide medical information and advice. Messages are responded to within 24 hours.
- Wellness and prevention information – We encourage healthy living. Our member outreach will continue to include reminders for needed care and missed services, sharing information about evidence-based care guidelines, diagnostic and treatment options, community-based resources and automated outreach efforts with references to web-based self-management tools.

We encourage you to promote the use of the member portal during interactions with your patients. Members can sign up online **AetnaBetterHealth.com/WestVirginia**, or they can call Member Services at **1-888-348-2922.**

Educating Members

The federal Patient Self-Determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Aetna Better Health shall not prohibit, or otherwise restrict, a practitioner or provider acting within the lawful scope of practice, from advising or advocating on behalf of an Aetna Better Health member who is his or her patient:

- For the Aetna Better Health member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- For any information the Aetna Better Health member needs in order to decide among all relevant treatment options.
- For the risks, benefits, and consequences of treatment or non-treatment.
- For the Aetna Better Health member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Further, we shall not discriminate against practitioners or providers that serve high-risk populations or specialize in conditions that require costly treatment. Additionally, each managed care member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected as specified in 45 CFR Part 164.

Patient Self-Determination Act

All practitioners and providers are required to comply with the Patient Self-Determination Act (COBRA '90, Sections 4206 and 4751) as described below:

- Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the practitioner or provider about patient rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
- Provide written information to all adult individuals on patient policies concerning implementation of such rights.
- Document any moral or religious objections that would stop a member from making advance directives and ensure this documentation is part of the member's medical record.
- Document in the patient's medical record whether or not the individual has executed an advance directive.
- Not condition the provision of care or otherwise discriminate against a patient based on whether or not he/she has executed an advance directive.
- Ensure compliance with requirements of state law (whether statutory or recognized by the courts) concerning advance directives.
- Provide (individually or with others) education for staff and the community on issues concerning advance directives.

For more information on Advance Directive requirements, see Chapter 4.

Primary Care Practitioners (PCP)

PCPs are defined as practitioners who specialize in:

- Family practice,
- General practice,
- Internal Medicine, or
- Pediatrics.

The PCP's role is to:

- Manage and coordinate the overall health care of members
- Provide behavioral health services within the scope of their practice
- Make appropriate referrals to participating practitioners or providers (including behavioral health)
- Obtain prior authorization for any referrals to non-participating practitioners or providers
- Provide or arrange for on-call coverage 24 hours/day, 7 days/week
- Accept new members unless we have been provided with written notice of a closed panel
- Facilitate adherence to the EPSDT Periodicity Schedule
- Maintain comprehensive and legible medical records
- Follow MCO-established procedures for coordination of in-network and out-of-network services for Aetna Better Health enrollees
- Share member health records and information in accordance with professional standards and applicable state and federal laws

Specialist Practitioners

- Agree to discuss treatment of members with the PCP
- Render or arrange any continuing treatment, including hospitalization, which is beyond the specific treatment authorized by the PCP
- Communicate any assessments or recommended treatment plans to the PCP
- Obtain prior authorization for specified non-emergent inpatient and specified outpatient covered services
- Maintain comprehensive and legible medical records
- Share member health records and information in accordance with professional standards and applicable state and federal laws

Specialist Practitioners Acting as PCP

In limited situations, an enrollee may select a specialist practitioner to serve as their PCP. In these instances, the specialist must be able to demonstrate the ability to provide comprehensive primary care. Specialists who perform primary care functions within certain practitioner classes, care settings, or facilities include but are not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics or other practitioners and providers.

Practitioner/Member and Provider/Member Relationships

Aetna Better Health requires all participating practitioners and providers to discuss treatment options with patients who are our members. This allows a member to make an informed decision about their course of treatment with knowledge of both the possible benefit limitations and treatment options. Information discussed between the physician and the member is to be kept confidential.

Emergency Services

Authorizations are not required for emergency services. In an emergency, please advise the member to go to the nearest emergency department. If a practitioner or provider is not able to provide services to a member who needs emergent care, or if they call after hours, the member should be referred to the closest emergency department.

Urgent Care Services

Practitioners and providers serve the medical needs of our members and are required to adhere to all appointment accessibility standards. In some cases, it may be necessary to refer members to a network urgent care center

(after hours in most cases). Please reference the online directory on our website and select an "Urgent Care Facility" in the specialty drop down list to view a list of participating urgent care centers located in the network.

Periodically, we will review unusual urgent care and emergency room utilization. Trends will be shared and may result in increased monitoring of appointment accessibility.

Lab Services

It is Aetna Better Health's policy that laboratory services should be provided by a contracted vendor for lab services if the lab services are not provided in the practitioner's or provider's office. When participating practitioners or providers send lab work to a vendor that we have not contracted with to perform lab services, the practitioner or provider is responsible for the charges pursuant to Chapter 3, subheading "Use of non-participating practitioners/providers."

Physicians may be reimbursed for certain laboratory services in the office if immediate results of the tests will affect the care of the patient or course of therapy. Please refer to your specific contract with us in order to determine the lab services that you are contracted to perform.

Genetic Testing

Some lab procedures, such as Genetic testing, may require prior authorization.

Non-Covered Services

As stated in your Participation Agreement with Aetna Better Health, you may not bill the member for services that are not covered by Aetna Better Health unless you notify the member before you provide and/or order the non-covered service and the member indicates in writing their willingness to pay out of pocket. You also must require that the member execute a form to the effect that the services are not a covered benefit, and the form must clearly identify the specific service that is not covered. A general acknowledgement of liability for non-payment is not an acceptable form. You may be held responsible for the charges associated with the non-covered service if you do not have an executed form indicating that the member understands the service is non-covered and is willing to pay out-of-pocket.

Home and Community Based Services (HCBS)

Home and Community Based Services often provide services to our members in their homes. There may be times when an interruption of service may occur due to an unplanned hospital admission or short-term nursing home stay for a member. While services may have been authorized for caregivers and agencies, practitioners or providers should not bill for any days that fall between the facility admission and discharge dates or any day during which services were not provided. This could be considered fraudulent billing. HCBS practitioners or providers may be required to work with Aetna Better Health Case Managers.

Court Ordered Services

Aetna Better Health will reimburse practitioners/providers for court-ordered treatment services that are covered under the Medicaid or CHIP State Plan and deemed medically necessary. The court order determination of medical necessity is subject to review, determination and member appeal process and a copy of the court order is required.

Medical Home

The National Center for Medical Home Implementation defines a medical home as a community-based primary care setting which provides and coordinates high quality, planned, family-centered: health promotion, acute illness care and chronic condition management. Performance/care coordination requirements of a medical home include the ability to:

- Provide comprehensive, coordinated health care for members and consistent, ongoing contact with members throughout their interactions with the health care system, including but not limited electronic contacts and ongoing care coordination and health maintenance tracking
- Provide primary health care services for members and appropriate referral to other health care professionals or behavioral health professionals as needed
- Focus on the ongoing prevention of illness and disease

- Encourage active participation by an enrollee and the enrollee's family, guardian, or authorized representative, when appropriate, in health care decision making and care plan development
- Facilitate the partnership between members, their personal physician, and when appropriate, the enrollee's family; and
- Encourage the use of specialty care services and supports.

Self-Referral/Direct Access

Aetna Better Health has an open-access network, where members may self-refer or directly access services without a referral from their PCP. We encourage all members to discuss specialty care with their PCP, who can coordinate needed services. Services must be obtained from an in-network Aetna Better Health practitioner or provider. There are exceptions to this, however; emergency, family planning, federally qualified and rural health centers and tribal clinic services do not require prior authorization for in-network or out-of-network practitioners or providers. Enrollees may access these services from a qualified practitioner or provider enrolled with the State of West Virginia in the West Virginia Medicaid or CHIP program.

Second Opinions

Aetna Better Health members have the right to a second opinion from a qualified health care professional any time the member wants to confirm a recommended treatment. A member may request a second opinion from a practitioner within our network. Practitioners should refer the member to another network practitioner within an applicable specialty for the second opinion.

Members will incur no expenses other than standard co-pays for a second and or third opinion provided by a participating practitioner, as applicable under the member Certificate of Coverage. Out-of-network services must receive prior authorization and are approved only when an in-network practitioner or provider cannot perform the service. The member will incur no more cost for an out of network second opinion than they would if the service was obtained in- network.

Procedure for Closing a PCP Panel

A PCP who no longer wishes to accept new Aetna Better Health members may submit a written notification to Provider Services to close his or her panel. In this situation, any new member who is not an established patient of that PCP cannot select that PCP's office with an approved closed panel.

A PCP may re-open a "closed" panel by submitting a written notification to Provider Services. This change will be made on the first of the month following submission of the request, no less than thirty days from receipt of the written request. Additional time may be necessary to update printed materials.

When an Aetna Better Health member chooses a PCP who has a "closed" panel, Member Service will notify the subscriber of the physician's panel status. If the physician chooses to make an exception to accept the member, the physician should contact Member Services for assistance in facilitating an over-ride to assign members to their practice on a case-by-case basis.

Non-compliant Members/PCP Transfer (Termination)

Practitioners and providers are responsible for delivering appropriate services to facilitate enrollee understanding of their health care needs. Practitioners and providers should strive to manage members and ensure compliance with treatment plans and with scheduled appointments. We will assist in the resolution of member specific compliance issues, by providing comprehensive member education and care management protocols. Please contact Provider Services for additional assistance in resolving member issues.

If member non-compliance issues persist, additional steps can be taken to address these situations including transfer of the member from a practice. West Virginia's Bureau of Medical Assistance Services (BMS) Managed Care Program has a process in place for the PCP, as well as Aetna Better Health (Health Plan) to request transfers of members to another PCP. The PCP or Health Plan may request that the member be transferred to another PCP, based on the following or similar situations:

- The PCP has sufficient documentation to establish that the member/practitioner relationship is not mutually acceptable, e.g., the member is uncooperative, disruptive, does not follow medical treatment, does not keep appointments, etc.
- Travel distance substantially limits the member's ability to follow through the PCP services/referrals.
- The PCP has sufficient documentation to establish fraud or forgery, or evidence of unauthorized use/abuse of the service by the member. (Note: Fraud and abuse investigation protocols are activated accordingly to investigate all identified potential cases).

The PCP and Health Plan must not request a transfer due to an adverse change in the member's health, or adverse health status. The above reasons do not include a situation where a PCP has terminated a PCP-member relationship prior to managed care enrollment, unless the PCP can establish that the reason(s) for termination still remains an issue. The criteria for terminating an Aetna Better Health member from a practice must not be more restrictive than the PCP's general office policy regarding terminations for non-Aetna Better Health members.

Dismissal of Patients from Practice

It is recommended that your practice have an established policy for dismissing patients from the practice. Aetna Better Health members should be seen and treated in the same manner as any other patient you see. Services or appointments cannot be refused in emergency or urgent care situations unless you have provided a member with at least 30 days' notice and requested that they select another practitioner or provider. In the event of a member dismissal from your practice, the member should be notified in writing and you must continue to manage emergent services during this time period. It is recommended that the practice submit a copy to Aetna Better Health of the dismissal notification letter sent to the member. If requested, we can assist the member in selecting a new physician and determine whether the termination needs to be addressed for care management intervention or forwarded to the compliance department.

This policy is to be used for special situations with specific patients only where just cause exists for dismissing the patient. If you are wishing to close your practice to new patients, please notify us in writing with the effective date of the change.

Member Transfer from Terming Practitioner Guidelines

Except in the case of death or illness, the Practitioner agrees to notify Aetna Better Health at least ninety (90) days in advance of disenrollment and agrees to continue care for his or her panel members for up to thirty (30) day after such notification or until another PCP is chosen or assigned.

We will make a good faith effort to give written notice of termination of a contracted practitioner or provider, at least thirty (30) days prior to the termination date, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated practitioner or provider. It is the practitioner's or provider's responsibility to provide timely notification as indicated in the participation contract if they are requesting a termination from the network.

Member Continuity of Care

When a practitioner terms, Aetna Better Health allows a member to continue an ongoing course of treatment with the provider/practitioner for up to ninety (90) calendar days from the date of Aetna Better Health's member Notification of Provider Termination letter. Aetna Better Health's definition of "ongoing course" is defined as a member receiving treatment from a practitioner during the previous six (6) months for a condition that requires follow-up care or additional treatment, or the services have been prior authorized, such as in the case of a member who is scheduled for a surgical procedure. Members receiving maternity services are allowed to continue with the practitioner who is being terminated through the completion of the member's postpartum care for members already in their second or third trimester of pregnancy. An authorization may be necessary for these services. Practitioners and providers may also contact our Care Management Department for assistance with continuity of care.

Aetna Better Health reserves the right to extend the transition period if the extension is determined to be clinically appropriate.

Member Notification of Termination

The notification sent to members by Aetna Better Health includes the following information:

1) Member name, address and Aetna Better Health member number
2) Reason for the change
3) Name, address and telephone number of the new PCP

Exception: If the PCP has moved out of state, and the PCP is no longer within coverage distance to the Aetna Better Health member, the PCP will be treated as a terminated PCP.

Medical Records Review

All participating Primary Care Practitioners (PCPs); defined as family practice, general or internal medicine and pediatrics, who provide medical care in ambulatory settings must comply with the Health Plan's Medical Record Documentation standards. The following standards are required:

Medical Record Documentation Standards		
1	**Name or ID present on each page of the record**	The patient's name or ID number should be recorded on each page of the medical record or electronic file (i.e. all notes, lab reports and consult reports).
2	**Personal Data**	The record contains appropriate personal data such as age, sex, address, employer, home and work telephone numbers, and marital status, as applicable. All patients must have their own chart.
3	**Entries in the record contain author signature or initials**	The provider of service for face-to-face encounters must be appropriately identified on medical records via their signature and physician specialty credentials (e.g., MD, DO, DPM etc.). Alterations to the record are signed.
4	**All entries are dated**	
5	**Legibility**	The medical record should be complete and legible to someone other than the writer.
6	**Allergies**	Medication allergies and adverse reactions are prominently noted in chart. Absence of allergies (noted as NKA – no known allergies) is noted in an easily recognized location.
7	**Past Medical History Completed and is easily identified** (for patients seen three or more times)	Past history including serious accidents, operations, and illnesses. Family history including a review of medical event, diseases, and hereditary conditions that may place the patient at risk may be included. For children past medical history relates to prenatal care, birth.
8	**Age-Appropriate Immunization record** (for patients 13 and under)	An immunization record (for children up to age 13) is up to date and when subsequent immunizations are required, as applicable.
9	**EPSDT Documentation**	Fully document all elements of each EPSDT assessment, including anticipatory guidance, behavioral health assessment, and follow-up activities according to state-required guidelines.
10	**Prescribed Meds, including dosages and dates of initial or refill Rx**	Evidence of prescribed medications, including dosages and dates of initial or refill prescriptions are present in the record. This list should be updated each visit.
11	**Identification of Current Problems**	Significant illness, medical condition, psychological conditions, and health maintenance concerns are identified in the medical record. Format can be a classical separate listing of problems or an updated summary of problems in the progress note section (usually during a periodic health exam). During a well-child visit, for children between ages of 3 and 17, counseling for nutrition and physical activity is documented at least annually.

Medical Record Documentation Standards		
12	**Alcohol/ Substance Abuse/ Smoking*** (For patients 12 years or older, seen three or more times)	For patients 12 years and older, there is documentation concerning alcohol, tobacco products, and/or substance abuse.
13	**Consultations, referral and specialist reports**	Consultations, referrals, labs, and x-ray reports have the ordering physician's initials or other documentation signifying review or are documented in progress notes; significantly abnormal lab and imaging study results have as explicit notation in the record and follow-up plans.
14	**Communication/Discharge summaries regarding emergency care and hospitalizations.**	There is evidence of communication/ discharge summaries from the hospitals and/or Emergency Care if applicable.
15	**Family Planning/Reproductive Health** (For patients 15-44, seen three or more times)	For patients 15-44 years old, there is documentation of family planning discussion, including assessments of sexual activity, contraception, STD screening, and/or counseling.
16	**Advanced Directives present** (for patients 18 years of age or older)	There is evidence of advance directives noted and whether or not the advance directive has been executed in the chart for patients 18 years of age or older.
17	**History and Physical examination**	Appropriate subjective and objective information is obtained for the presenting complaints at each visit.
18	**Treatment Plan**	Treatment Plan (prescriptions, studies, instructions, diagnostic, therapeutic procedures) is documented and appropriate for the patient's diagnosis and risk factors.
19	**Diagnostics tests and therapies**	If a diagnostic service (test or procedure) or therapy is ordered, planned, scheduled, or performed at the time of the encounter, the type of service, e.g., lab or x-ray should be documented.
20	**Follow-up Plan/ Return Visit for each Encounter**	Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed. Unresolved problems from previous visits are addressed in subsequent visits.

The Quality Management (QM) Department will audit PCP practices for compliance with the documentation standards. Written notification of aggregated review results are provided to practitioner offices after the Medical Record audit has been completed.

The health plan will provide routine education to practitioners and their respective clinics. This may include but is not limited to, articles on our Provider website on the medical record review (MRR) process, highlights of low compliance, adaptation of any universal forms by Aetna Better Health and updates of any changes within the process and standards. Tools utilized to implement and maintain education may include emails, fax alerts, website, provider manual, webinars, forums and mailings.

Practitioners and providers understand and agree that members shall not be required to reimburse them for expenses related to providing copies of patient records or documents to any local, State or Federal agency (i) pursuant to a request from any local, State or Federal agency (including, without limitation, the Centers for Medicare and Medicaid Services ("CMS") or such agencies' subcontractors; (ii) pursuant to administration of Quality Management, Utilization Review, and Risk Management Programs, including the collection of HEDIS data; or (iii) in order to assist Aetna in making a determination regarding whether a service is a Covered Service for which payment is due hereunder.

All records, books, and papers of practitioners and providers pertaining to members, including without limitation, records, books and papers relating to professional and ancillary care provided to members and financial, accounting and administrative records, books and papers, shall be open for inspection and copying by Aetna, its designee and/or authorized State or Federal authorities during practitioner's or provider's normal business hours. In addition, Practitioner or Provider shall allow Aetna to audit Practitioner's or Provider's records for payment and claims review purposes. Practitioner or provider further agrees to maintain all such members' records for services rendered for a period of time in compliance with state and federal laws.

Medical Record Audits

We conduct annual medical record audits to assess compliance with established standards. Medical records may also be requested when we are responding to an inquiry on behalf of a member, practitioner or provider, administrative responsibilities or quality of care issues. Practitioners and providers should respond to these requests promptly. Medical records must be made available to Aetna, Bureau of Medical Assistance Services, CMS, and Federal or state authorities and their agents for quality review and/or audit upon request. Records must be stored in a secured HIPAA (Health Insurance Portability and Accountability Act of 1996) compliant manner.

Access to Facilities and Records

Federal and local laws, rules, and regulations require that network practitioners and providers retain and make available all records pertaining to any aspect of services furnished to an enrollee or their contract with Aetna Better Health for inspection, evaluation, and audit for the longer of:

- A period of ten years from the end of the contract with Aetna Better Health
- The date the State of West Virginia or their designees complete an audit; or
- The period required under applicable laws, rules, and regulations.

Documenting Enrollee Appointments and Eligibility

When scheduling an appointment with a member over the telephone or in person (i.e. when a member appears at an office without an appointment), practitioners and providers must verify eligibility and document the member's information in the medical record. Please access the Aetna Better Health website to electronically verify eligibility or call the Member Services department at **1-888-348-2922**.

Missed or Cancelled Appointments

Practitioners and providers should:

- Document in the member's medical record, and follow-up on missed or canceled appointments
- Conduct affirmative outreach to an enrollee who misses an appointment by performing minimum reasonable efforts to contact the member
- Notify Member Services when a member continually misses appointments.

Members may not be charged a fee for missed or canceled appointments.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health InformationTechnology for Economic and Clinical Health Act (HITECH) at 42 U.S.C. 17931 et. Seq. have many provisions affecting the health care industry, including transaction code sets, privacy and security provisions. HIPAA impacts what is referred to as covered entities; specifically, practitioners, providers, health plans, and health care clearinghouses that transmit health care information electronically. HIPAA has established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All practitioners and providers are required to adhere to HIPAA regulations. For more information about these standards, please visit https://www.hhs.gov/hipaa/for-professionals/privacy/index.html . In accordance with HIPAA guidelines, practitioners and providers may not interview enrollees about medical or financial issues within hearing range of other patients.

The HITECH Act of 2009 strengthened HIPAA in many ways: expanding the range of the HIPAA Security Rule; requiring compliance with certain Privacy Rule standards and the Breach Notification Rule; and providing tougher penalties for HIPAA compliance failures. HITECH requires that all information that the practitioner or provider obtains through the performance of services included in the provider Contract must be treated as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or enrollees of BMS programs. For more information about HITECH, please visit https://www.healthit.gov/topic/laws-regulation-and-policy/health-it-legislation.

Practitioners and providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records, confidential practitioner, provider and enrollee information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:

- Train office staff on HIPAA.
- Consider the location and handling of the patient sign-in sheet
- Keep patient records, papers and computer monitors out of view and in secure (locked) locations; and
- Have electric shredder or locked shred bins available.

The following enrollee information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information protected health information (PHI). The Privacy Rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
- "Individually identifiable health information" is information, including demographic data, that relates to:
  - The individual's past, present or future physical or mental health, or condition.
  - The provision of health care to the individual.
  - The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
  - Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

Practitioners' or providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health. Release of data to third parties requires advance written approval from the enrollee, except for releases of information for the purpose of individual care and coordination among practitioners and providers, releases authorized by enrollees or releases required by court order, subpoena or law.

Additional privacy requirements are located throughout this Manual. For additional information, please visit: **www.hhs.gov/hipaa/index.html.**

Member Privacy Rights

Aetna Better Health privacy policy states that members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. Our privacy policy conforms with 42 and 45 CFR (Code of Federal Regulations): relevant sections of the HIPAA that provide enrollee privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526, and 528).

Our policy also assists Aetna Better Health personnel, practitioners and providers in meeting the privacy requirements of HIPAA when enrollees or authorized representatives exercise privacy rights through privacy request, including:

- Making information available to enrollees or their representatives about our practices regarding their PHI
- Maintaining a process for enrollees to request access to, changes to, or restrictions on disclosure of their PHI
- Providing consistent review, disposition, and response to privacy requests within required time standards
- Documenting requests and actions taken

Member Privacy Requests

Members may make the following requests related to their PHI ("privacy requests") in accordance with federal, state, and local law:

- Make a privacy complaint
- Receive a copy of all or part of the designated record set
- Request amendments/correction to records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI
- Receive confidential communication.
- Receive a Notice of Privacy Practices

A privacy request must be submitted by the member or member's authorized representative. A member's representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the enrollee or the deceased enrollee's estate. Except for requests for a health plan Notice of Privacy Practices, requests from members or a member's representative must be submitted to us in writing.

Cultural Competency

Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender identity, age, mental or physical disability, sexual orientation, genetic information or medical history, homelessness, ability to pay or ability to speak English. Aetna Better Health expects practitioners and providers to treat all enrollees with dignity and respect as required by federal law. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

Aetna Better Health has developed effective practitioner and provider education programs that encourage respect for diversity, foster skills that facilitate communication within different cultural groups and explain the relationship between cultural competency and health outcomes. These programs provide information on enrollees' diverse backgrounds, including the various cultural, racial, and linguistic challenges that enrollees encounter, and we develop and implement proven methods for responding to those challenges. To access Aetna Better Health's online cultural competency courses, please visit: **AetnaBetterHealth.com/WestVirginia/providers/education/competency**.

Practitioners and providers may receive education about such important topics as:

- The impact that an enrollee's religious and/or cultural beliefs can have on health outcomes (e.g., belief in non-traditional healing practices)
- The problem of health illiteracy and the need to provide patients with understandable health information (e.g., simple diagrams, communicating in the vernacular, etc.)
- History of the disability rights movement and the progression of civil rights for people with disabilities
- Physical and programmatic barriers that impact people with disabilities accessing meaningful care
- The reluctance of certain cultures to discuss mental health issues and of the need to proactively encourage enrollees from such backgrounds to seek needed treatment.

Our Provider Relations and outreach representatives may conduct cultural competency training during practitioner and provider orientation meetings, which is designed to help practitioners and providers:

- Bridge cultures
- Build stronger patient relationships

- Provide more effective care to ethnic and minority patients
- Work with patients to help obtain better health outcomes

Health Literacy – Limited English Proficiency (LEP) or Reading Skills

In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and State requirements, Aetna Better Health is required to ensure members with Limited English Proficiency (LEP) have meaningful access to health care services. Because of language differences and inability to speak or understand English, persons identified with LEP are often excluded from programs they are eligible for, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, gender identity, genetic information or medical history, ability to pay or ability to speak English. Practitioners and providers are required to treat all members with dignity and respect, in accordance with federal law. Practitioners and providers must deliver services in a culturally effective manner to all members, including:

- Those with limited English proficiency (LEP) or reading skills
- Those with diverse cultural and ethnic backgrounds
- The homeless
- Individuals with physical and mental disabilities

Interpretive Services

Practitioners and providers are required to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist practitioners and providers with this, Aetna Better Health makes its telephonic language interpretation service available to facilitate member interactions. These services are free to the member and practitioner or provider. However, if the practitioner or provider chooses to use another resource for interpretation services other than those provided by Aetna Better Health, the practitioner or provider is financially responsible for associated costs.

Language interpretation services are available for use in the following scenarios:

- If a member requests interpretation services, Aetna Better Health Member Services Representatives will assist the practitioner or provider via a three-way call to communicate in the member's native language.
- For outgoing calls, Member Services dials the language interpretation service and uses an interactive voice response system to conference with a member and the interpreter.
- For face-to-face meetings, our staff (e.g., Case Managers or Member Services) can conference in an interpreter to communicate with a member in his or her home or another location.
- When practitioners or providers need interpreter services and cannot access them from their office, they can call Member Services to link with an interpreter.

We provide alternative methods of communication for enrollees who are visually impaired, including large print and/or other formats. Alternative methods of communication are also available for hearing impaired members, which include accessing the state Relay line (**711**). Contact Member Services for more information on how to access alternative formats/services for visually or hearing impaired.

Aetna Better Health requires the use of professional interpreters, rather than family or friends. Further, we provide member materials in other formats to meet specific enrollee needs. Practitioners and providers must also deliver information in a manner that is understood by the member. If interpreter services are declined, please document this in the members' medical record. This documentation could be important if a member decides that the interpreter he or she has chosen has not provided him/her with full knowledge regarding his/her medical history, treatment or health education.

During the credentialing process for Aetna Better Health, we ask what other languages are spoken in the office so we may refer our members with special language needs.

Translation Services

If a language barrier prevents you from communicating effectively with our members, we have translation services available to assist. Our language line provides interpreter services at no cost to you. Please contact Member Services. Let the Member Service Representative know that you need an interpreter and what language is needed. They will make the connection for you. Our translation service provides interpreters for more than 140 languages and is available during the Member Service hours of 8:30 a.m. to 5 p.m. Eastern Standard Time. Call Member Services toll-free at **1-888-348-2922.**

Individuals with Disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. Practitioner offices must be accessible to persons with disabilities. Practitioners and providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. Site visits will be conducted by our Provider Services staff to ensure that network practitioners and providers are compliant.

Receipt of Federal Funds, Compliance with Federal Laws and Prohibition on Discrimination

Practitioners and providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- The Americans With Disabilities Act
- Federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law
- The False Claims Act (31 U.S.C. §§ 3729 et. seq.)
- The anti-kickback statute (section 1128B(b) of the Social Security Act); and
- HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164.

In addition, our network practitioners and providers must comply with all applicable CMS laws, rules and regulations for, and, as provided in applicable laws, rules and regulations, network practitioners and providers are prohibited from discriminating against any enrollee on the basis of health status.

Practitioners and providers shall provide covered services to members that are generally provided by a practitioner or provider and for which the practitioner or provider has been credentialed by Aetna Better Health. Such covered services shall be delivered in a prompt manner, consistent with professional, clinical and ethical standards and in the same manner as provided to practitioner's or provider's other patients. Practitioner or Provider shall accept members as new patients on the same basis as Practitioner or Provider is accepting non-members as new patients. Practitioner or Provider shall not discriminate against a member on the basis of age, race, color, creed, religion, gender, sexual orientation, gender identity, national origin, health status, use of covered services, income level, or on the basis that member is enrolled in a managed care organization or is a Medicare or Medicaid beneficiary.

Out-of-network Services

If Aetna Better Health is unable to provide necessary medical services, covered under the contract, within the network of contracted practitioners and providers, Aetna Better Health will coordinate these services adequately and in a timely manner with out-of-network practitioners/providers, for as long as the organization is unable to provide the services. We will provide any necessary information for the member to be able to arrange the service. The member will not incur any additional cost for seeking these services from an out-of-network practitioner or provider.

For Medically Necessary covered emergency services, Aetna Better Health will cover a member's out-of-network hospital fees until the member's records, clinical information and care can be transferred to a network hospital, or until such time as the member is no longer enrolled with Aetna Better Health, whichever is shorter.

Clinical Practice Guidelines

Aetna Better Health adopts evidence-based clinical practice guidelines (CPGs) for medical and behavioral health conditions from nationally recognized sources. We do this to promote consistent application of evidence-based treatment methodologies. We make the CPGs available to our network practitioners to help improve health care. We review CPGs at least every two years. We may review them more frequently if national guidelines change within the two-year period. We provide CPGs for informational purposes only. They aren't meant to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of practitioners. These guidelines don't dictate or control a practitioner's clinical judgment regarding the appropriate treatment of a member in any given case.

Clinical Practice Guidelines are available on our website at:
AetnaBetterHealth.com/WestVirginia/providers/guidelines. For assistance in obtaining hard copies from the nationally recognized sources, contact your Provider Relations Representative

Division of Surveillance and Disease Control Reporting

Health care practitioners and providers are required to report certain diseases by state law. This is to allow for disease surveillance and appropriate case investigation/public follow-up. The three primary types of diseases that must be reported are:

Sexually Transmitted Disease Program: Per WV Statute Chapter 16-4-6 and Legislative Rules Title 64, Series 7, practitioners and providers must report cases involving a sexually transmitted disease to the Division of Surveillance and Disease Control.

Tuberculosis Program: Per WV Statute Chapter 26-5A-4 and WV Regulations 16-25-3, practitioners and providers must report individuals with diseases caused by M. tuberculosis to the WV Bureau for Public, DSDC, and TB Program.

Communicable Disease Program: Per WV Legislative Rules Title 6-4, Series 7, practitioners and providers must report cases of communicable disease noted as reportable in West Virginia to the local health departments in the appropriate time frame and method outlined in legislative rules. Per legislative rule, reports of category IV diseases, including HIV and AIDS, are to be submitted directly to the State Health Department, not to local jurisdictions.

Federal Reporting Requirements

Aetna Better Health is required to report the following to the State:

- Abortions must comply with the requirements of 42 CFR 441. Subpart E – Abortions. This includes completion of the information form, Certification Regarding Abortion.
- Hysterectomies and sterilizations must comply with 42 CFR 441. Subpart F – Sterilizations. This includes completion of the consent form.
- EPSDT services and reporting must comply with 42 CFR 441 Subpart B – Early and Periodic Screening, Diagnosis, and Treatment.

For a list of the state requirements and procedures for the above listed services, please refer to the Medicaid Physician Provider Manual at https://dhhr.wv.gov/bms/Pages/Manuals.aspx .

Financial Liability for Payment for Services

Under no circumstances should a practitioner or provider bill a member (or a person acting on behalf of a member) for payment of fees that are the legal obligation of Aetna Better Health. However, a network practitioner or provider may collect co-payments from members in accordance with the terms of the member's Certificate of Coverage or their Member handbook. Practitioners or providers must make certain that they are:

- Agreeing not to hold members liable for payment of any fees that are the legal obligation of Aetna Better Health and must indemnify the member for payment of any fees that are the legal obligation of Aetna Better

Health of Virginia for services furnished by practitioners or providers that have been authorized by Aetna to service such members, if the member follows Aetna's rules for accessing services described in the approved member handbook.
- Agreeing not to bill a member for medically necessary services covered under the plan and to always notify members prior to rendering services.
- Agreeing to clearly advise a member, prior to furnishing a non-covered service, of the member's responsibility to pay the full cost of the services.
- Agreeing that when referring a member to another practitioner or provider for a non-covered service must ensure that the member is aware of his or her obligation to pay in full for such non-covered services.

Health Care Acquired Conditions (HCAC)

Procedures performed on the wrong side, wrong body part, wrong person or wrong procedure is referred to in this policy as "Wrong Site/Person/Procedure," or WSPPs. The Centers for Medicare and Medicaid Services (CMS) has adopted a national payment policy that all WSPP procedures are never reimbursed to facilities. CMS prohibits practitioners and providers from passing these charges on to patients. Subject to CMS policy, we will not reimburse practitioners or providers for WSPPs or for any WSPP-associated medical services. In addition, we prohibit passing these charges on to patients.

HCACs are preventable conditions that are not present when patients are admitted to a hospital but become present during the course of the patient's stay. These preventable medical conditions were identified by CMS in response to the Deficit Reduction Act of 2005 and meet the following criteria:

1) The conditions are high cost or high volume or both
2) Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis
3) Could reasonably have been prevented through the application of evidence-based guidelines.

Effective October 1, 2008, CMS ends payment for the extra care resulting from HCACs. CMS also prohibits passing these charges on to patients. Subject to CMS policy, Aetna Better Health will not reimburse hospitals for the extra care resulting from HCACs.

General Reminders

- Obtain prior authorization from Aetna Better Health for all services requiring prior authorization.
- Referrals to non-participating practitioners or providers, regardless of level-of-care must be pre-authorized, unless specifically exempted from authorization, such as Family Planning and Emergency services.
- Authorization approval does not guarantee authorized services are covered benefits.
- Benefits are always contingent upon member eligibility at the time of service.
- Understand that prior authorization is approved by Aetna Better Health based upon the present information that has been made available to the health plan. Payment for prior-authorized, covered services is subject to the compliance with our Utilization Management Program, contractual limitations and exclusions, and coordination of benefits.
- Accept medical necessity and utilization review decisions; refer to the Complaint and Appeal Section of this manual if a practitioner or provider disagrees with a review decision or claim that has been processed.
- Agree to collect only applicable copayments, if any, from members. Except for the collection of copayments, practitioners and providers shall look only to Aetna Better Health for compensation for medically necessary covered services.
- Agree to meet credentialing and recredentialing requirements of Aetna Better Health.
- Practitioners and providers must safeguard the privacy of any information that identifies a particular member in accordance with federal and state laws and to maintain the member records in an accurate and timely manner.
- Practitioners and providers shall provide covered benefits and health care services to members in a manner consistent with professionally recognized standards of health care. Practitioners and providers must render or order only medically appropriate services.
- Practitioners and providers must obtain authorizations for all hospitalizations and confinements, as well as services specified in this manual and other practitioner and provider communications as requiring prior authorization.

- Practitioners and providers must fully comply with the terms of their agreement and maintain an acceptable professional image in the community.
- Practitioners and providers must keep their licenses and certifications current and in good standing and cooperate with Aetna Better Health's recredentialing program. Aetna must be notified of any material change in the practitioner's or provider's qualifications affecting the continued accuracy of the credentialing information submitted to us.
- Practitioners and providers must obtain and maintain professional liability coverage as is deemed acceptable by Aetna Better Health through the credentialing/recredentialing process. Practitioners and providers must furnish us with evidence of coverage upon request and must provide the plan with at least thirty (30) days' notice prior to the cancellation, loss, termination or transfer of coverage.
- Practitioners and providers shall ensure the completeness, truthfulness and accuracy of all claims and encounter data submitted to us including medical records data required and ensure the information is submitted on the applicable claim form.
- In the event that the practitioner, provider or Aetna Better Health seeks to terminate the agreement, it must be done in accordance with the contract.
- Practitioners and providers must submit demographic or payment data changes at least sixty (60) days prior to the effective date of change.
- Practitioners and providers shall be available to Aetna Better Health members as outlined in the Access and Availability Standards section of this manual. Practitioners will also arrange 24-hour, on-call coverage for their patients by practitioners that participate with Aetna Better Health, as outlined within this manual.
- Practitioners and providers must become familiar and to the extent necessary, comply with Aetna Better Health members' rights as outlined in the "Members Rights and Responsibilities" section of this manual.
- Participating practitioners and providers agree to comply with our Provider Manual, quality improvement, utilization review, peer review, complaint procedures, credentialing and recredentialing procedures and any other policies that Aetna Better Health may implement, including amendments made to the mentioned policies, procedures and programs from time to time.
- Practitioners and providers will ensure they honor all Aetna Better Health members' rights, including, but not limited to, treatment with dignity and respect, confidential treatment of all communications and records pertaining to their care and to actively participate in decisions regarding health and treatment options.
- Practitioners and providers of all types may be held responsible for the cost of service(s) where prior-authorization is required, but not obtained, or when place of service does not match authorization. The member shall not be billed for applicable service(s).
- We encourage practitioners and providers to contact Provider Relations at any time if they require further details on requirements for participation.

Practitioner and Provider Responsibilities to Aetna Better Health

Federal Law and Statutes (as outlined in the contract) are detailed below.

Civil Rights, Equal Opportunity Employment, and Other Laws

Practitioner or provider shall comply with all applicable local, State and Federal statutes and regulations regarding civil rights laws and equal opportunity employment, including but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and the Americans with Disabilities Act. Practitioner or provider guarantees its compliance with the State and Federal statutes and regulations regarding civil rights laws and equal opportunity employment. Breach of this provision shall constitute a material breach of this Agreement.

Debarment and Prohibited Relationships

Practitioner or provider acknowledges that Aetna Better Health may not contract with practitioners or providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. Practitioner or provider warrants that it is not so excluded. Should Practitioner's or Provider's exclusion status change, Practitioner or Provider agrees to notify us immediately. Further, Practitioner or Provider shall not employ or contract for the provision of health care, utilization review, medical social work or administrative services with any individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act.

Practitioner or provider acknowledges that Aetna Better Health is prohibited from maintaining a relationship with entities that have been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, and that Aetna Better Health is prohibited from having relationships with "affiliates" as the term is defined under the Federal Acquisition Regulation.

Federal Sanctions

In order to comply with Federal law (42 CFR 420.200 - 420.206 and 455.100 - 455.106) health plans with Medicaid or Medicare business are required to obtain certain information regarding the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid or Medicare program. The Centers for Medicaid and Medicare Services (CMS) requires Aetna Better Health and its subsidiaries to obtain this information to demonstrate that we are not contracting with an entity that has been excluded from federal health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid. The Controlling Interest Worksheet will be included with the credentialing application, as well as, the recredentialing application. This Form must be completed, signed and dated when returned from the practitioner or provider.

Medically Necessary Services

All services provided to Aetna Better Health members must be medically necessary and reflect:

- Health care services and supplies which are medically appropriate.
- Necessary to meet the basic health needs of the member.
- Rendering in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service.
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or government agencies.
- Consistent with the diagnosis of the condition.
- Provision of services required for means other than convenience of the member his/her practitioner or provider.
- Provision that is no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
- Provision of services of demonstrated value.
- Provision of services that is no more intense level of service than can be safely provided.

New/Advanced Technology

Emerging technologies are a daily occurrence in health care. We have a Medical Technology Committee (MTC) to review
new and emerging technology. The committee uses evidenced based clinical research to make determinations regarding the efficacy of the new technologies. Practitioners and providers are advised of new technologies approved for coverage by Aetna's MTC via routine communications including the Provider website, bulletins and ongoing provider relations.

Please be advised of the following guidelines for these specific advanced technologies:

- Robotics: Reimbursement for charges related to Robotics assistance during surgery will be based solely on the base standard procedure. There will be no additional reimbursement for the use of robotics. Members shall not be held responsible; and
- When a claim is submitted for 3-D Imaging, we do not issue additional reimbursement for the Advanced Technology rendering component. Such component is incidental, and reimbursement will be based solely on the base standard imaging study/procedure. Members shall not be held responsible.

Health Care Reform Update Payments Outside the United States

Effective January 1, 2011, Section 6505 of the Patient Protection and Affordable Care Act prohibits Medicaid health plans from making payments to financial institutions or entities located outside of the United States. This includes payments to practitioners, providers, hospitals, and ancillary healthcare practitioners or providers for items or

services provided to Medicaid enrollees through the Aetna Better Health contract with the State of West Virginia. If you or your organization are located outside of the United States, or utilize a financial institution located outside of the United States, your payments will not be sent until you are located in the United States, or in the latter instance, establish a relationship with an entity located in the United States.

Practitioner/Provider Satisfaction Survey

Annually, we conduct a practitioner/provider satisfaction survey. If you have any questions or would like to participate please call Member Services at **1-888-348-2922**.

Practitioner/Provider Responsibilities to Members

This section outlines the practitioner and provider responsibilities to our members. This information is provided to providers to assist in understanding the requirements in place for Aetna Better Health.

Establishing an early primary care physician relationship is the key to ensuring that every Aetna Better Health member has access to necessary health care and to providing continuity and coordination of care. The member will already have chosen a primary care physician on the date their enrollment is effective. If necessary, we will assign a primary care physician in the event that no selection is made.

PCP Qualifications and Responsibilities

To participate as an Aetna Better Health practitioner, the PCP must:

1) Be a State-enrolled practitioner and agree to comply with all pertinent Medicaid/CHIP regulations.
2) Sign a contract with Aetna Better Health as a PCP which explains the PCP's responsibilities and compliance with the following requirements:
    a. Treat Aetna Better Health members in the same manner as other patients.
    b. Provide Aetna Better Health members with a medical home including, when medically necessary coordinating appropriate referrals to services that typically extend beyond those services provided directly by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health services, and other community-based agency services.
    c. As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs members such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDS, self-referrals for women's health services, family planning services, etc.
    d. Provide continuous access to PCP services and necessary referrals of urgent or emergent nature available 24-hours, 7 days per week, access by telephone to a live voice (an employee of the PCP or an answering service) or an answering machine that must immediately page an on-call medical professional so referrals can be made for non-emergency services or so information can be given about accessing services or procedures for handling medical problems during non-office hours.
    e. Do not refuse an assignment or transfer a member or otherwise discriminate against a member solely on the basis of age, sex, race, physical or mental handicap, national origin, type of illness or condition, except when that illness or condition can be better treated by another practitioner or provider type.
    f. Ensure that ADA requirements and other appropriate technologies are utilized in the daily operations of the physician's office, e.g., TTD/TDD and language services, to accommodate the member's special needs.
    g. Maintain a medical record for each member and comply with the requirement to coordinate the transfer of medical record information if the member selects another PCP.
    h. Maintain a communication network providing necessary information to any MH/SA services practitioner or provider as frequently as necessary based on the member's needs. Note: Many MH/SA services require concurrent and related medical services, and vice versa. These services include, but are not limited to anesthesiology, laboratory services, EKGs, EEGs, and scans.
    i. Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., Vaccines for Children, communications regarding management of infectious or reportable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.
    j. Comply with all disease notification laws in the State of West Virginia.

k. Provide information to the Bureau as required.
l. Inform members about all treatment options, regardless of cost or whether such services are covered by the West Virginia Bureau for Medical Services.
m. Provide accurate information to the Health Plan in a timely manner so that PCP information can be exchanged with BMS and Aetna Better Health Provider Relations via the Provider Network File.

Advance Directives

We maintain written policies and procedures related to advance directives that describe the provision of health care when the member is incapacitated. These policies ensure the member's ability to make known his/her preferences about medical care before they are faced with a serious injury or illness.

Aetna Better Health's policy defines advance directives as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (statutory or as recognized by the courts of the State) relating to the provisions of health care when the individual is incapacitated. The Advance Directive policy details our obligation for Advance Directives with respect to all adult individuals receiving medical care by or through the health plan. These obligations include, but are not limited to:

- Providing written information to all adult individuals concerning their rights under state law to make decisions concerning their medical care, accept or refuse medical or surgical treatment and formulate Advance Directives for health care.
- Documenting in a prominent part of the individual's medical record whether the individual has executed an Advance Directive.
- Not conditioning the provision of care or otherwise discriminating against an individual based on whether that individual has executed an Advance Directive.
- Ensuring compliance with requirements of state law concerning Advance Directives.
- Educating Health Plan staff, practitioners and providers on Advance Directives.

Our policies provide guidance on Aetna's obligations for ensuring the documentation of any Advance Directive decisions in the practitioner's or provider's member records, and monitoring compliance with advance directives including the right of the member to note any moral or religious beliefs that prohibit the member from making an advance directive.

Aetna Better Health will ensure that our practitioners and providers are informed of their responsibilities in regard to advance directives. Provider Relations staff educates network practitioners and providers on information related to advance directives through the Participation Contract, Provider Manual, Provider bulletins and during Provider Relations' on- site office visits.

Aetna Better Health Network Management is responsible for:

- Ensuring participation contracts contain requirements that support members' opportunity to formulate advance directives.
- Ensuring the Provider Manual contains guidance on Advance Directives for Aetna Better Health members.

Quality Management (QM) staff distributes Medical Record Documentation Standards annually to the practitioners and providers. One of the Medical Record Documentation standards requires that if a member has an executed Advance Directive, a copy must be placed in the member's medical record. If the member does not have an executed Advance Directive, the medical record would provide documentation that a discussion regarding Advance Directives has occurred between the practitioner or provider and the member.

Aetna Better Health is committed to ensuring that adult members understand their rights to make informed decisions regarding their health care. Aetna Better Health's Advance Directives Policy and Procedure provides guidance on our obligations for educating members and practitioners/providers. We educate practitioners and providers on advance directives processes to ensure our members have the opportunity to designate advance directives.

At the time of enrollment, the health plan distributes written information to members on advance directives (including West Virginia State law) through the Member Handbook. The information in the materials includes:

- Member's rights under State law, including a description of the applicable State law.
- Aetna Better Health's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
- The member's right to file complaints regarding non-compliance with the State.

Aetna Better Health is responsible for educating members and practitioners or providers about advance directives rights. The Compliance Officer is responsible for ensuring advance directives information appears, no less than annually, in our materials. Advance directives information is available in the:

- Member Handbook
- Member Newsletter
- Web site
- Provider Manual
- Provider Bulletins

Case managers educate and offer advance directives information when appropriate. Additionally, practitioners and providers are audited during on-site reviews to ensure policy and procedure compliance.

Children with Serious Emotional Disorder Waiver (CSEDW)

Program Overview

In addition to providing services under the Mountain Health Trust and Mountain Health Promise programs, Aetna Better Health is also the Managed Care Organization for children and youth participating in the Children with Serious Emotional Disorder Waiver (CSEDW) program.

The CSEDW is a Medicaid Home and Community Based Services (HCBS) waiver program authorized under §1915(c) of the Social Security Act. This waiver provides services (that are additions to services available through the Medicaid State Plan) for children and youth ages three through their 21st birthday who are enrolled in the CSEDW program. The CSEDW allows West Virginia to provide a range of home and community-based services that allows children or youth who would otherwise require institutionalization to stay in their homes and communities.

By offering services in the home and community, West Virginia hopes to see fewer children and youth receive treatment in residential treatment facilities and psychiatric rehabilitation treatment facilities. Additionally, for children and youth coming home from placement, this waiver will allow for services and supports to continue in the child's home and community.

Children and youth who are enrolled in the CSEDW program must enroll with Aetna Better Health as the Managed Care Organization. Individuals who are not willing to enroll with Aetna are not eligible to enroll in the CSEDW program.

Eligibility Process for the CSEDW Program

For a child to be found eligible for the CSEDW program, the child must:

- Be an eligible West Virginia Medicaid member. Medicaid eligibility is independent of medical eligibility for the CSEDW and is not impacted by enrollment in the CSEDW
- Choose to receive services in the home and community over receiving services in an institutional setting
- Choose to enroll with Aetna Better Health
- Meet CSEDW medical eligibility
- Be at least three years of age and not yet 21
- Be a resident of West Virginia, even if presently living out of state in a Psychiatric Residential Treatment Facility (PRTF), and
- Be able to provide proof of residency upon application to the waiver

Enrollment in the CSEDW program is dependent upon the availability of a funded CSEDW slot.
Initial medical eligibility is determined through review of an Independent Psychological Evaluation (IPE) report completed by a Psychologist, who is a member of the Independent Psychological Network (IPN); which must include background information, mental status examination, a measure of intelligence, adaptive behavior, achievement and any other documentation deemed appropriate.

If a slot is not available, the child will receive a letter stating that the child has been placed on a Managed Enrollment List (MEL) in the chronological order in which the child was determined eligible. When a slot becomes available, a letter will be sent stating that the child may proceed with the enrollment process for the CSEDW program.

In the event that the child is assigned to an MCO other than the Mountain Health Promise MCO while the child is on the managed enrollment list, the child is required to transfer to Aetna Better Health when a funded slot becomes available.

If the child is on the program for a year, he or she will receive reassessment to make sure they remain eligible for the program. This reassessment will happen every year the child is on the CSEDW program and will happen up to 90 calendar days prior to the child's anchor date. The anchor date is the first day of the following month that the child was originally found to be eligible for the CSEDW program.

For complete 'Eligibility and Enrollment' information please refer to Chapter 502: Children with Serious Emotional Disorder Waiver (CSEDW), which can be found here:
dhhr.wv.gov/bms/Programs/WaiverPrograms/CSEDW/Pages/SED.aspx

Chapter 5 – Credentialing and Practitioner/Provider Changes

Requests for Participation

All potential new practices or non-contracted practitioners and providers who apply for participation within the network(s) of Aetna Better Health are subject to the same processes to ensure consistency is established and followed when making a determination whether a practitioner's or provider's request for application to the network will be accepted or denied. No provider acting within the scope of his or her license or certification under applicable state law, shall face discrimination with respect to participation, reimbursement, or indemnification.

Aetna Better Health will only accept as participating practitioners or providers those practitioners or providers:

1) For which there is a network need
2) That willingly accept the terms of the negotiated contracts, including reimbursement rates; and
3) Successfully pass the health plan's credentialing standards.

Aetna's Credentialing Policy

Aetna's credentialing policy has adopted the highest industry standards, which are a combination of URAC/NCQA/CMS plus applicable state and federal requirements. Exceptions to these standards are reviewed and approved based on local access issues determined by the local health plan. Aetna must follow and apply the provisions of state statutes, federal requirements and accreditation standards that apply to credentialing activities.

Statement of Confidentiality

Practitioner and provider information obtained from any source during the credentialing/recredentialing process is considered confidential and used only for the purpose of determining the practitioner's or provider's eligibility to participate with in the Aetna Better Health network and to carry out the duties and obligations of Aetna operations, except as otherwise required by law.

Practitioner and provider information is shared only with those persons or organizations who have authority to receive such information or who have a need to know in order to perform credentialing related functions. All credentialing records are stored in secured/locked cabinets and access to credentialing records is limited to authorized personnel only. Individual computer workstations are locked when employees leave their workstation. Access to electronic practitioner and provider information is restricted to authorized personnel via sign-on security. All employees are trained and acknowledge training in accordance with federal HIPAA regulations. Disposal of all confidential documents must be via the locked confidential shred receptacles placed throughout the work area.

Credentialing/Recredentialing

Council for Affordable Quality Healthcare (CAQH)

Aetna Better Health uses current National Committee for Quality Assurance (NCQA) standards and guidelines for the review, credentialing and recredentialing of practitioners and uses the CAQH ProView. CAQH is a nonprofit alliance of America's leading health plans. CAQH ProView allows practitioners to submit one application to meet the needs of all the health plans and hospitals participating in the CAQH effort. To maintain the accuracy of the data, CAQH sends practitioners a reminder every 90 days to re-attest to their information.

Health plans and hospitals designated by practitioners obtain application information directly from the CAQH database. This eliminates the need for multiple organizations to contact the practitioner for the same information. CAQH gathers and stores detailed data for more than 1 million practitioners nationwide. Aetna Better Health uses CAQH ProView for credentialing all practitioner types and CAQH Proview is compliant with state-required credentialing applications.

Practitioners Excluded from Credentialing Requirements

- Practitioners who practice exclusively within the inpatient hospital setting and who are not Primary Care Practitioners and who provide care only as a result of the member being directed to or seeking care at the hospital.
- Practitioners who practice exclusively within freestanding facilities and who provide care for members only as a result of members being directed to or seeking care at the facility.

- Practitioners who are residents and practitioners who are doing temporary fellowships outside the hospital setting under supervision of a network participating practitioners(s) or provider(s).
- Covering practitioners (e.g., locum tenens).
- Rental network practitioners or providers that are specifically for out-of-area care, and there are no incentives communicated. Members have no obligation to seek care from rental network practitioners and may see any out-of-area practitioner; and
- Behavioral Health Practitioners that provide exclusively inpatient, Partial Hospital Program (PHP), Intensive Outpatient Program (IOP) or Residential services to members in an accredited, participating hospital or facility AND care for members only as a result of members being directed to or seeking care at the facility.

Initial Credentialing Individual Practitioners

Initial Credentialing is the entry point for practitioners to begin the contract process with the health plan. New practitioners, (with the exception of hospital-based practitioners) including practitioners joining an existing participating practice with Aetna Better Health, must complete the credentialing process and be approved by the Credentialing Committee. Practitioners may not treat members until they become credentialed.

Recredentialing Individual Practitioners

Aetna Better Health recredentials practitioners on a regular basis (every 36 months based on state regulations) to ensure they continue to meet health plan standards of care along with meeting legislative/regulatory and accrediting bodies (NCQA) requirements. Termination of the participation contract can occur if a practitioner/provider misses the 36-month timeframe for recredentialing.

Facility Licensure and Accreditation

Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as otherwise indicated.

Ongoing Monitoring

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

Practitioners/Providers Excluded from Participation in Federal Health Care Programs

We are prohibited from participating with or entering into any agreement with any individual or entity that has been excluded from participation in Federal Health Care Programs, including Medicare, Medicaid or the Children's Health Insurance Program.

The federal Health and Human Services – Office of Inspector General (HHS-OIG) has an online exclusions database available at **http://exclusions.oig.hhs.gov**. It is a comprehensive listing of individuals and firms that are excluded from participation in federal health care programs. This database allows practitioners and providers to screen their practice, managing employees, contractors, etc., to determine whether any has been excluded from participating in federal health care programs.

Practitioners and providers are encouraged to check their information in the exclusions database on a monthly basis. Practitioners and providers must immediately report to us any exclusion information discovered.

Additions or Terminations

In order to meet contractual obligations and state and federal regulations, practitioners and providers who are in good standing are required to report any terminations or additions to their agreement at least 90 days prior to the change in order for us to comply with CMS and/or accreditation requirements. Practitioners and providers are required to continue providing services to enrollees throughout the termination period.

Practitioners and providers are responsible to notify Provider Relations no less than 30 days in advance of any changes in professional staff at their offices (physicians, physician assistants, or nurse practitioners), practice locations, telephone numbers, fax numbers or email addresses. Administrative changes in office staff may result in the need for additional training. Contact Provider Relations to discuss staff training, if needed.

Non-Discrimination

We do not discriminate against any qualified applicant based on race, color, creed, ancestry, religion, age, disability, gender, national origin, citizenship, sexual orientation, disabled veteran, or types of procedures performed or types of patients the practitioner specializes, or Vietnam veteran status, in accordance with Federal, State, and Local laws.

All employees of Aetna Better Health are required to attend online training within 60 days of hire and annually thereafter, which requires passing a comprehensive quiz at the end of each training module. This training includes our Code of Business Conduct and Ethics, and Unlawful Harassment, both of which address our non- discrimination policies and practices.

We maintain a compliance line **1-844-405-2016**, which is available 24 hours per day, 7 days per week for all employees, as well as members, practitioners and providers to call to report compliance matters. All Aetna Better Health employees have been educated on the compliance line and are encouraged to call if they suspect discrimination.

For any questions regarding the credentialing or recredentialing status of a practitioner or provider, please contact Provider Relations.

Chapter 6 – Member benefits

Aetna Better Health believes that the essence of a successful Medicaid or CHIP program is the extent that members understand their benefits and how to access them. We also go beyond simply educating members about covered services; we put incentive programs in place to encourage benefit utilization. Benefit packages differ, depending on the member's age and whether the member is covered under Mountain Health Trust or West Virginia Health bridge.

Non-emergent Transportation

Arrangements for non-emergency, non-ambulance transportation of members will be made by BMS's contracted statewide transportation broker, Modivcare. Members can call 844-549-8353 for more information.

Enhanced Services

In conjunction with the provision of covered services noted, we are also responsible for the following:

- Placing a strong emphasis on programs to enhance the general health and well-being of enrollees. Specifically, we develop and implement programs that encourage enrollees to maintain a healthy diet, engage in regular exercise, get an annual physical examination, and avoid all tobacco use
- Making health promotion programs available to the enrollees
- Promoting the availability of health education classes for enrollees
- Providing education for enrollees with, or at risk for, a specific disability or illness
- Providing education to enrollees, enrollees' families, and other health care practitioners or providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities
- Upon request from BMS, collaborate on projects that focus on improvements and efficiency in the overall delivery of health services.

Co-payments Collection

Beginning January 1, 2014, WV Medicaid co-payment amounts for eligible members are based on the following:

- Cost Sharing applies to current and newly eligible individuals
- Services cannot be refused for populations with income at or below 133% FPL if the member is unable to pay the copay amount; and
- Maximum out of pocket (OOP) cannot exceed 5% of the members' quarterly household income.

The following WV Medicaid populations and services are exempt from copays:

- Pregnant women including pregnancy-related services up to one-year post-partum
- Children under age 21
- Native American and Alaska natives
- Intermediate Care Facility or IID services
- Preventive services
- Individuals in Nursing Homes
- Hospice services
- Medicaid Waiver services
- Breast and Cervical Cancer Treatment Program
- Family Planning services
- Behavioral Health services
- Emergency services

The following WV CHIP populations and services are exempt from copays:

- Preventive Services
- Medical Home Physician Visits
- Native American and Alaskan natives
- Pregnant women over 19 years of age

Co-payment Amounts

Medicaid Co-payments:

Medical Services	Up to 50.00% FPL	50.01 – 100.00% FPL	100.01% FPL and Above
Inpatient Hospital (Acute Care)	No copay	$35	$75
Office Visits (Physicians and Nurse Practitioners)	$0	$2	$4
Outpatient Surgical Services in a Physician's Office; Ambulatory Surgical Center; or Outpatient Hospital (excluding emergency rooms)	No copay	$2	$4
Non-Emergency Use of Emergency Room	$8	$8	$8

CHIP Co-payments:

Medical Services	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
Physician Visit (non-medical home)	$5	$15	$20
Inpatient Hospital Admissions	No copay	$25	$25
Outpatient Surgical Services	No copay	$25	$25
Emergency Department (waived if admitted)	No copay	$35	$35
Dental Benefit	No copay	No copay	$25 copay for some non-preventative services

The WV CHIP out of pocket limits are as follows:

CHIP Out of Pocket Maximums:

# of Children Copay Maximum	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
1 Child Medical Maximum	$150	$150	$200
2 Children Medical Maximum	$300	$300	$400
3 or more Children Medical Maximum	$450	$450	$600
Dental Services	Does not apply	Does not apply	$150 per family

The member co-payment amount will be reflected on the remittance advice, if it is applicable. If you have questions regarding a member's co-payment amount, contact Member Services at **1-888-348-2922**.

Aetna Better Health members do not have coinsurance or deductibles. Co-pays may not be collected for missed appointments. Providers are not permitted to waive co-payments.

Providers will collect applicable co-payments for:

- Inpatient and outpatient services
- Physician office visits, including nurse practitioner visits
- Non-emergency use of an emergency room
- Caretaker relatives age 21 and up

- Transitional Medicaid members age 21 and up
- Any other members that are not specifically exempt.

Member Communications

We have numerous ways to inform enrollees about covered health services. No program information document shall be used unless it achieves a Flesch total readability score of 6.9 or lower (at or below a 6th grade educational level). The document must set forth the Flesch score and certify compliance with this standard. (These requirements shall not apply to language that is mandated by Federal or State laws, regulations or agencies.)

Some documents are available in alternate formats and in non-prevalent languages, including:

- Member Handbook — A comprehensive members document that explains all covered benefits and services and exclusions and limitations.
- Public Website — General information and member handbook are available online.
- Member online portal — A web portal providing members easy access to health care information and materials. The member portal is a secure, password-protected site that ensures confidential information is only available to the member.
- Member newsletter — member publication featuring articles about covered services such as immunizations, well-child checks, urgent and emergency care, mammograms, etc.
- Care Management and Chronic Condition Management letters and flyers with education on disease processes.

Aetna Better Health's teams also communicate covered benefits and services to members on a regular basis.

- Member Services – representatives are trained and dedicated to West Virginia's lines of business. Service representatives describe benefits to members and answer questions. Interpretation services are available in several languages.
- Complaints and Appeals – assists members with completing the complaint and appeal process when dissatisfied with services or benefit reductions.
- Care Management – works closely with individual members to develop and execute care plans.
- Prior Authorization (PA) – PA staff work with the practitioner and provider community to process referral and prior authorization requests.
- Outreach Coordinators — our community partners help support our members' understanding of Aetna Better Health covered services.
- Network Practitioners/Providers — training materials and the Provider Manual include West Virginia Aetna Better Health covered services information.

Early and Periodic Screening, Diagnostics, and Treatment (EPSDT)

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a child preventive health component of Medicaid. HealthCheck is the name for West Virginia's EPSDT Program. The HealthCheck Program promotes regular preventive medical care and the diagnosis and treatment of any health problem found during a screening. Well-child visits, also known as Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) services, are important to make sure children are healthy and stay healthy. The EPSDT benefit under HealthCheck covers all medically necessary and preventive health care services for members up to age 21 (age 19 for CHIP members). Covered screening services are medical, mental health, vision, hearing, and dental. Both sick and well care services are provided to members at no cost.

Network practitioners and providers are subject to Aetna Better Health's documentation requirements for EPSDT Services and must ensure that documentation includes the information to address the questions contained on the WV HealthCheck forms found at https://dhhr.wv.gov/HealthCheck/providerinfo/Pages/default.aspx. EPSDT services shall also be subject to the following additional documentation requirements:

- The medical record shall include the age-appropriate screening provided in accordance with the periodicity schedule.
- Documentation of a comprehensive screening shall at a minimum, contain a description of the components described below. We recommend that practitioners and providers send reminders to parent when screenings, immunizations, and follow-up services are due.
- Use of the HealthCheck screening questions and/or protocols.

EPSDT Screenings

Practitioners and providers should use the following guidelines to provide comprehensive EPSDT services to Aetna Better Health or screenings, from birth through age 18 for CHIP members and age 20 for Medicaid members, at intervals which meet reasonable standards of practice, as specified in the EPSDT medical periodicity schedule established by the DHHR. The medical screening shall include:

- A comprehensive health and developmental history, including assessments of both physical, mental and behavioral health development
- A comprehensive unclothed physical examination that should be supervised, including vision and hearing screening; dental inspection; and a nutritional assessment
- Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines. Immunizations shall be reviewed at each screening examination, and necessary immunizations must be administered
- Appropriate laboratory tests at participating lab facilities. The following recommended sequence of screening laboratory examinations should be provided by Aetna Better Health participating practitioners and providers. Additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary
  - Hemoglobin/Hematocrit
  - Urinalysis
  - Tuberculin test (for high-risk groups); and
  - Blood lead assessment using blood level determinations as part of scheduled periodic health screenings appropriate to age and risk must be done for children according to the following schedule:
    - Between 12 months and 24 months of age; and
    - Between the ages of two to six years if the child has not previously been screened for lead poisoning.

All screening shall be done through a blood lead level determination. Results of lead screenings, both positive and negative results, shall be reported to the local DHHR office.

Health Education/Anticipatory Guidance

This includes referral for further diagnosis and treatment or follow-up of all correctable abnormalities uncovered or suspected.

EPSDT screening services shall reflect the age of the child and shall be provided periodically according to the following schedule:

HealthCheck Screening Schedule for Well-child visits	
Stage	**Ages for Well-child visits**
Infancy	Birth, 3-5 days old, by 1 month, 2 months, 4 months, 6 months and 9 months
Early Childhood	12 months, 15 months, 18 months, 24 months, 30 months, 3 years and 4 years
Middle Childhood and Adolescence	Every year from age 5 to age 21 (age 19 for CHIP members)

EPSDT Vision Services

Participating practitioners and providers should perform periodic vision assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum according to the DHHR EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in vision, including eyeglasses. Vision screening in an infant shall mean, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for visual acuity shall be done.

EPSDT Hearing Services

All newborn infants will be given a hearing screening before discharge from the hospital after birth. Those children who do not pass the newborn hearing screening, those who are missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Participating practitioners and providers should perform periodic auditory assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum at intervals recommended in the DHHR EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids. Hearing screening shall mean, at a minimum, observation of an infant's response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child.

EPSDT Dental Services

Dental screening in this context shall mean, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection. Certified primary care practitioners may receive a reimbursement for fluoride varnish application if they have completed a certified training course with WVU School of Dentistry prior to performing and billing us for this service. A referral to a dentist at or after one year of age is recommended. A referral to a dentist shall be mandatory at three years of age and annually thereafter through age 18 for CHIP members and age 20 for Medicaid members.

Other EPSDT Services

Participating practitioners and providers should perform such other medically necessary health care, diagnostic services, treatment, and other measures as needed to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Referrals

If a problem is found or suspected during a well-child visit, the (suspected) problem must be diagnosed and treated as appropriate. This may mean referral to another practitioner or provider or self-referral for further diagnosis and treatment.

It is not always possible to complete all components of the full medical screening service. For example, immunizations may be medically contraindicated or refused by the caregiver. The caregiver may also refuse to allow their child to have a lead blood level test performed. When this occurs, an attempt should be made to educate the caregiver with regard to the importance of these services. If the caregiver continues to refuse the service, the child's medical record must document the reason the service was not provided. By fully documenting in the child's medical record the reason these services were not provided, the Practitioner or Provider may bill a full medical screening service even though all components of the full medical screening service were not provided.

Direct Access to Care - to Women's Health Specialists

We provide female members direct access to women's health specialists for routine and preventive health care services. Routine and preventive health care services include, but are not limited to prenatal care, breast exams, mammograms and pap tests. Direct access means that Aetna Better Health cannot require women to obtain a referral or prior authorization as a condition to receiving such services from specialists in the network. Direct access does not prevent us from requesting or requiring notification from the practitioner for data collection purposes. Members may

also seek these services from a participating practitioner or provider of their choice, if their primary care practitioner is not a women's health specialist. Women's health specialists include, but are not limited to, obstetricians, gynecologists, nurse practitioners, and certified nurse midwives.

Family Planning Services

Our members have direct access for family planning services without a referral and may also seek family planning services at the practitioner or provider of their choice (in or out of network).
The following services are included:

- Annual gynecological exam
- Annual pap smear
- Lab services
- Contraceptive supplies, devices and medications for specific treatment
- Contraceptive counseling

A comprehensive family planning exam includes the following:

- Assessing a member's risk for unintended pregnancy, poor pregnancy outcome, or need for family support services
- Age-appropriateness of information provided to members and the need for confidentiality of information
- Pregnancy diagnosis and counseling, including:
    - Referral to a participating obstetrical practitioner/provider for early entry into prenatal care, for members diagnosed as pregnant who wish to continue the pregnancy
    - Information on all legal options available for members diagnosed with unintended pregnancies and, if they desire, referral for appropriate obstetrical and gynecological service
    - Information about the availability of contraceptive methods for non-pregnant members
- Education, including:
    - Reasons why family planning is important to maintain individual and family health
    - Basic information regarding reproductive anatomy
    - Risk factors and complications of various contraceptive methods
    - Information on the transmission, diagnosis and treatment of sexually transmitted diseases
    - Education about acquired immunodeficiency syndrome (AIDS)/human immunodeficiency virus (HIV)
    - Procedures of self-breast examination

For members 15-44 years of age, the medical record should include documentation of a discussion regarding family planning which may include assessments of sexual activity, contraception, STD screening, and/or counseling OR documentation that the member saw a family planning practitioner.

Treatment for STDs

Aetna Better Health members can access any participating practitioner or provider or State enrolled practitioner or provider for treatment of a sexually transmitted disease without prior approval from Aetna Better Health.

Transportation Service

Emergency transportation is covered for all Aetna Better Health members.

Arrangements for non-emergency, non-ambulance transportation of members will be made by BMS's contracted statewide transportation broker, Modivcare. Members can call 844-549-8353 for more information.

Sterilization/Hysterectomy

We will cover a sterilization or hysterectomy determined to be medically necessary by the attending physician in consultation with the patient.

All federal and state laws regarding this benefit must be adhered to, ensuring the completion of the required forms, and shall comply with the requirements of 42 CFR 441. Subpart F.

The required forms are located on the Bureau for Medical Services website. The consent form should be submitted with the claim.

Maternity Services

Most of our benefit plans which require the selection of a Primary Care Practitioner, also allow female members to choose an OB/GYN practitioner in addition to her Primary Care Practitioner. Female members, age 13 or older, whether or not they are in a plan where they choose an OB/GYN practitioner, may receive covered routine and preventative health care services from a participating obstetrical/gynecological practitioner without a referral or prior authorization. OB/GYNs performing annual exams should bill with the appropriate preventive medicine CPT code.

The length of stay for a vaginal delivery is two nights. The length of stay for a cesarean section delivery is four nights. For mothers or babies whose medical condition warrants additional days, prior authorization is required. Shorter stays shall occur where patient and physician agree.

Benefits for inpatient care and a home visit(s) are determined in accordance with the criteria outlined in the most current version of the “Guidelines for Perinatal Care” prepared by the AAP and ACOG or the “Standards for OB/GYN Services” prepared by ACOG. The health plan is allowed a six-month period to incorporate any changes in these guidelines or standards in its procedures. If the procedure outlined below is found not to be in accordance with these guidelines and standards, then the conflicting procedure in the guidelines and standards prevails.

Each expectant mother is mailed information during her pregnancy that includes a request to notify Aetna Better Health of the baby’s pediatrician. In addition, the health plan sends mothers-to-be a Pregnancy Health packet which includes information on the stages of pregnancy, eating smart for two, and provides a list of community classes and resources.

Practitioners are encouraged to notify the health plan of newly diagnosed pregnancies within 7 days.

Newborn Enrollment

Newborn children of eligible members will be automatically enrolled with the mother’s health plan, unless mothers choose a different health plan for their child. Newborns will be enrolled in the plan on birth month for a minimum of 60 days starting with the day of birth.

To maintain Medicaid eligibility, newborns must have their own Medicaid numbers before the end of the birth month, plus two-month time frame. To ensure that you will continue being paid for services, you should remind mothers to contact their local DHHR office to obtain a Medicaid number for their child.

Home Health Care and Durable Medical Equipment (DME)

Home health care, DME, Home Infusion and Orthotics/Prosthetic Services may require prior authorization. All services should be coordinated with the member’s PCP or the referring specialist practitioner in accordance with his/her plan of treatment based on medical necessity, available benefit, and appropriateness of setting and network availability.

Emergency Services

Prior approval by the member’s primary care practitioner and medical/surgical plan is not required for receipt of emergency services. Education of the member is necessary to ensure they are informed regarding the definition of an "emergency medical condition," how to appropriately access emergency services, and encourage the member to contact the PCP and plan before accessing emergency services. Member Services and Care Management will also assist in educating members regarding Emergency Services.

An emergency medical condition is a medical condition that manifests itself by acute symptoms of sufficient severity, (including severe pain), that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

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

d. Serious harm to self or others due to an alcohol or drug abuse emergency/mental health condition.

Aetna Better Health must be notified of an emergency admission within 24 hours or by the end of the next working day if the 24-hour deadline falls on a weekend or legal holiday. However, earlier notification greatly facilitates the utilization review process and allows Aetna Better Health to determine during the stay whether or not medical criteria for coverage are met.

If you are unsure regarding the necessity for prior authorization, please call Health Services at **1-844-835-4930**. For weekend or after-hours admissions, you can call Health Services on the next working day at **1-844-835-4930**. For urgent/emergent issues after hours, call **1-844-835-4930** and you will be directed to an on-call nurse that can assist you. You may also fax to **1-866-366-7008.**

Members that inappropriately seek routine and/or non-emergent services through emergency department visits will be contacted by Aetna Better Health and educated on visiting their PCP for routine services and/or treatments. Use of ground ambulance transportation under the prudent lay person's definition of emergency will not require authorization for the ambulance service.

24-Hour Nurse Line

Aetna Better Health provides a free 24-Hour Nurse Line for members. The 24-Hour Nurse Line is a clinical triage service consisting of a package of health care information services, call center services, triage, and other services. In providing the clinical triage services, the program uses algorithms, clinical tools and supporting software designed to enable Registered Nurses to assess a member's level of health risk based on the presenting symptoms and to route them to an appropriate level and timing of care.

24-Hour Nurse Line services are provided based on the answers to the questions in the algorithms. The nurse can help the member decide if the member needs to go to the hospital, urgent care facility, or their doctor -or- if the member can care for him or herself or family member at home. The 24-Hour Nurse line does not provide benefit information.

The 24-Hour Nurse Line call center is staffed 7 days a week, 24 hours a day, including holidays and can be reached at **1-855-200-5975** or **TTY: 711**.

After Hours Behavioral Health Crisis Line

Aetna Better Health provides an after-hours Behavioral Health Crisis Line for members. Members who call in are immediately connected to a licensed clinician who triages the call and directs the member to the appropriate level of care and/or community resources. Our Care Management staff follow-up with members within 24 hours to ensure their needs have been met and to offer additional assistance.

The Behavioral Health Crisis Line is available 7 days a week beginning at 5:00pm EST and can be reached at **1-888-348-2922** Option 2.

Pharmaceutical Management

The pharmacy benefit for outpatient prescriptions is carved out to the State. Aetna Better Health continues to manage medications delivered in practitioner/provider offices and inpatient facilities. For questions about member benefits related to Medicaid member prescription medications, contact Gainwell Technologies at **1-888-483-0797**. For questions about member benefits related to WV CHIP member prescription medications, contact Express Scripts at **1-855-230-7778**. For questions regarding in-office or inpatient medications contact Aetna Better Health at **1-888-348-2922**.

Immunizations and Injectable(s)

We reimburse immunizations and injectable(s) based on a list of rates developed by the West Virginia Bureau for Medical Services and adopted by Aetna Better Health. These rates are updated quarterly.

Please reference the Immunization Chart on our website at **AetnaBetterHealth.com/WestVirginia.**

Routine Childhood Immunization

Aetna Better Health enrollees aged birth through 18 are eligible for vaccines through the West Virginia Vaccines for Children (VFC) Program. Primary Care Practitioners who administer childhood immunizations for Aetna Better Health members must enroll in the West Virginia Vaccines for Children Program. Practitioners who choose not to enroll in the Vaccines for Children program should refer Aetna Better Health members to governmental public health entities that participate in the VFC program. When an Aetna Better Health member aged birth through 18 needs immunizations, you may obtain these immunizations free from DHHR. You should only bill us for administering this drug. If you run out of VFC vaccinations, you may use your private stock for Aetna Better Health members and ask the DHHR to reimburse you.

Rabies Vaccinations

Rabies vaccinations are a covered benefit for our members. A PCP or specialist who elects to provide this service in their office can contact Gainwell Technologies to obtain the vaccine. Members may also be directed to the nearest participating hospital emergency room or the local Health Department for the vaccine. Claims will pay in accordance with the member's benefit and the corresponding place and/or practitioner or provider of service.

Injectable(s)

All therapeutic office-based injectable(s) covered under the member's medical benefit require prior authorization before the service is rendered. You may call Health Services at **1-844-835-4930** to obtain prior authorization for these types of injectable(s). Injectable(s) are reimbursed according to national rates negotiated by Aetna Better Health with various national vendors. These rates are updated quarterly. Examples of injectable(s) reviewed under the member's medical benefit include (but are not limited to):

- Remicade
- Aranesp
- Neulasta
- Natalizumab and
- Unlisted or miscellaneous drug codes such as (but not limited to) J9999, J3490, J3590

Women, Infants and Children (WIC) Nutrition Program

Aetna Better Health benefits do not include WIC (the Special Supplemental Nutrition Program for Women, Infants and Children). Our benefits do not provide transportation for members to pick up WIC checks. The West Virginia Department of Health provides the WIC Program. If a member wants to find out more about WIC, they can call their local health department, or call toll- free **1-888-942-3663**.

How can you obtain WIC materials, forms, and information?

For WIC materials and forms or for more information, you can download many of the WIC program forms and education materials at **http://ons.wvdhhr.org/AboutWIC/WomenInfantsandChildrensProgram/tabid/1141/Default.aspx .**

Dental Services

Children

Children under 21 years of age are eligible for dental check-ups. Other dental services covered for children include: restorative services, orthodontics, and other dental or oral surgery services needed to correct dental problems.

Orthodontic services will be completed in-full regardless of a member's enrollment or eligibility.

Anesthesia for dental services is covered by Aetna Better Health, but requires a prior authorization.

Adult

For adults 21 years and older, diagnostic, preventive, restorative and emergency dental services are covered. Non-emergency dental services are limited to $1,000 per calendar year (other limitations apply). Dental services may be provided by a dentist, orthodontist, or oral surgeon.

Some examples of a dental emergency include:

- Severe pain
- Hemorrhage
- Traumatic injury to the teeth and surrounding tissue
- Unusual swelling of the face or gums

SKYGEN USA is the dental vendor for Aetna Better Health. If you need to talk to SKYGEN USA, call SKYGEN USA customer service at **1-855-844-0623.**

Pregnancy Dental Services

Up to two routine oral exams and cleanings per pregnancy are covered and do not require prior authorization.

Oral Surgery Including Dental Accidents

Oral surgery is covered only for the cases below and require prior authorization. Aetna Better Health benefits only cover repairs needed for daily living.

Covered Oral Services:

- Oral surgery is covered for non-dental surgical and hospital procedures for birth defects (like cleft lip and cleft palate);
- Medical or surgical procedures within or next to the oral cavity or sinuses that are medically needed
- Dental services medically needed because of an accidental injury are covered when your doctor submits a plan of treatment to us. The medical service must be performed within six months of the injury; and
- Medically needed medical or surgical procedures within or next to the oral cavity or sinuses resulting from the removal of tumors and cysts.

Not Covered Oral Services:

- Cosmetic services or repairs that Aetna Better Health decides are not needed for daily living
- Other procedures involving the teeth or areas around the teeth including, but not limited to:
  - Shortening of the mandible or maxilla for cosmetic purposes
  - Correction of malocclusion or mandibular retrognathia
  - Treatment of natural teeth due to diseases
  - Repair, removal or replacement of sound natural teeth
  - Diagnosis and treatment of temporomandibular joint (TMJ) pain dysfunction syndrome

Interpretation Services

We provide interpreter services for non-English speaking or hearing and visually impaired members. Aetna will also screen during member contacts if interpretation services are needed to more efficiently provide assistance. We will provide, upon request, alternative formats of all member related materials. Providers and members may inquire about interpretive services in their community by contacting Member Services at **1-888-348-2922**.

Aetna Better Health offers a TDD line for hearing-impaired members. Aetna Better Health Member Services Department can establish interactions with other TDD lines and/or be available to mediate a TDD line call to a health care Practitioner or Provider by contacting Aetna Better Health Member Services at **1-888-348-2922 (TTY: 711).** When a member prefers that available family or friend interpret for them or decides not to utilize Aetna Better Health' hearing impaired support service line, this preference must be noted in the member's medical record.

Socially Necessary Services (SNS)

KEPRO is the Socially Necessary Services vendor for Aetna Better Health members. If you need to talk to KEPRO, call KEPRO's SNS department at **1-800-461-9371.**

Chapter 7 – Member Eligibility and Enrollment and Member Rights

Member Services

Member Services provides information for Members on eligibility, benefits, complaints, education and available programs. Member advocates can provide services for Members having trouble with their health care needs, finding practitioners or providers, filing complaints or appeals, as well as assist practitioners or providers with non-compliant Members and/or discharges. We can be reached at **1-888-348-2922**.

Eligibility

Eligibility determinations are made by the West Virginia Bureau for Medical Services (BMS), prior to enrollment with a managed care plan, including Aetna Better Health. Any coverage prior to the enrollment effective date with Aetna Better Health is also determined by the West Virginia Bureau for Medical Services (BMS).

Enrollment

After members apply for Medicaid or CHIP with the Department of Health and Human Resources, the agency may place individuals or families in Mountain Health Trust or WV CHIP depending on the eligibility decision. To enroll in a health plan, members of those programs will need to contact the state's enrollment broker office. Eligible foster and adoptive families that are part of the Mountain Health Promise Program will be enrolled into Aetna Better Health.

A copy of both types of ID cards are shown below and a copy of the benefit plans is in the attachments section. For questions about either program contact your provider relations representative at **1-888-348-2922**.

Verification of Eligibility

Member eligibility and enrollment can and should be confirmed by utilizing one of several methods:

- West Virginia Medicaid automated Voice Response System (VRS) at **1-888-483-0793**. Your 10-digit Medicaid Provider number is required to access this system
- Call the WVCHIP Helpline at 1-877-982-2447
- Provider web portal eligibility search at **www.wvmmis.com**
- Aetna Better Health Member Services at **1-888-348-2922**

If you still have questions or issues related to the member's eligibility after checking the above sources, please contact our Provider Services department at **1-888-348-2922**.

Identification Cards (ID)

Upon enrollment into the Aetna Better Health plan, an ID card will be issued for each family member enrolled in Aetna Better Health plan. An ID card will be mailed to each new member when a PCP is selected or assigned.

Additional facts and directions are printed on the back of the card including the 24-hour Nurse Line phone number which is available to members.

Members are encouraged to always keep their identification card with them. If the card is lost or stolen, the member should call Member Services immediately to get a new card. Should a member present without a card or present with a State of West Virginia ID card, services should not be denied. To confirm the Aetna Better Health member's PCP selection, call Member Services at **1-888-348-2922**.

The Aetna Better Health identification card will include the following information:

- Aetna Better Health name
- Member name
- Member ID number
- Primary care practitioner name and telephone number
- Member Services telephone number
- Claim submission information
- 24-hour Nurse Line telephone number

- Behavioral Health/Crisis telephone number

PCPs may have an open or closed panel for Aetna Better Health members. Please contact your Provider Relations Representative for assistance.

Member Rights and Responsibilities

Aetna Better Health members have certain rights and responsibilities. Here is our member rights and responsibilities statement:

Member Rights

As a member of Aetna Better Health, you have rights around your health care. You have the right to:

- Be told about your rights and responsibilities.
- Get information about Aetna Better Health, our services, our practitioners and providers, and your.
- Be treated with respect and dignity and have your privacy protected.
- Get interpretation services if you do not speak English or have a hearing impairment.
- Not be discriminated against by Aetna Better Health.
- Access all services that Aetna Better Health must provide.
- Choose a practitioner or provider in our network.
- Take part in decisions about your health care.
- Accept or refuse medical or surgical treatment and choose a different provider.
- A second opinion at no cost (including out of network, if an in-network provider is not available). Learn about other treatment options and different courses of care no matter how much they cost and/or if Aetna Better Health will pay for it.
- Access your health information through technology platforms like Aetna Better Health's member portal and mobile app; and receive information on how to access them.
- Access the provider directory through Aetna Better Health's website, member portal, mobile app, or other Aetna Better Health technology platforms.
- Be aware of the information available on Aetna Better Health's website and other technology platforms.
- Ask for and get your medical records.
- Ask that your medical records be amended or corrected, if needed.
- Be sure your medical records are kept private.
- Tell us how we can improve our policies and procedures, including the member rights and responsibilities policy.
- Be free from abuse, neglect, financial exploitation, or any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation.
- Get covered services, no matter what your cultural or ethnic background is or how well you understand English.
- Get covered services regardless of any physical or mental disability, or if you are homeless.
- Get accessible services and receive reasonable disability accommodations.
- Refer yourself to in-network and out-of-network family planning providers.
- Get necessary services from an out-of-network provider if the services are not available within our network, for as long as our provider network is unable to provide them.
- Access certified nurse midwife services and certified pediatric or family nurse practitioner services.
- Get emergency post-stabilization services.
- Get emergency health care services at any hospital or other setting.
- Receive information about advance directives.
- Have your parent or a representative make treatment decisions when you can't.
- Submit a complaint or appeal about Aetna Better Health or the care it provides.
- A quick response to problems raised around complaints, grievances, appeals, authorization, coverage, and payment of services.
- Ask for a state fair hearing after a decision has been made about your appeal.
- Request and get a copy of this member handbook.
- Obtain advocacy on your behalf
- Disenroll from your health plan.

Member Responsibilities

As a member of Aetna Better Health, you have the responsibility to:

- Read through and follow the instructions in your Member Handbook
- Work with your PCP to manage and improve your health.
- Ask your PCP any questions you may have.
- Call your PCP any time you need health care.
- Give all information about your health to Aetna Better Health and your doctor. Tell your doctor if you do not understand your health problems. Work together with your doctor to make plans about your care.
- Show your ID card to each doctor before getting health services.
- Protect your member ID card. Do not lose or share it with others.
- Only use the emergency room (ER) for true emergencies.
- Keep your appointments.
- If you must cancel an appointment, call your PCP as soon as you can to let him or her know.
- Follow plans and instructions for care that you and your practitioner agree to.
- Follow your practitioner's recommendations about appointments and medications.
- Go back to your PCP or ask for a second opinion if you do not get better.
- Call Member Services at **1-888-348-2922** (TTY: **711**) whenever anything is unclear to you or you have questions.
- Contact DHHR Change Report Center at 1-877-716-1212 to report changes in family size, employment, address and/or phone number.
- Treat health care staff and others with respect.
- Tell Aetna Better Health if you have other health insurance, including Medicare.

Aetna Better Health distributes its member rights and responsibility statement to new members in enrollment kits and to existing members via newsletter and website access each year. Members can request a copy be mailed to them by contacting Member Services. We also distribute the member rights and responsibility statement to new practitioners when they join our network and to existing practitioners each year via the website.

Persons with Special Health Care Needs

We consider the following categories of enrollees to be of the special needs population:

- Children with special physical and/or mental health care needs
- Individuals with a physical disability
- Individuals with delays in development or a developmental disability
- Individuals with HIV/AIDS.

Our members with a disabling condition or chronic illness may have a specialist as a PCP. If you have a member that would benefit from a specialist acting as a PCP or are a specialist that is willing to be a PCP for a member, please contact Member Services **1-888-348-2922** to make the request. We encourage training for practitioners, providers and their staff to promote sensitivity to these special needs populations, as well as the special needs of the Medicaid and WV CHIP population in general.

The health plan is required to do the following for members identified as persons with special health care needs:

- Conduct an assessment in order to identify any special conditions of the member that require ongoing care management services
- Allow direct access to specialists (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs
- For individuals determined to require care management services, maintain documentation that demonstrates the outcome of the assessment and services provided based on the special conditions of the member Primary Care Practitioner (PCP) Assignment

Each Aetna Better Health member is assigned a PCP. Members are allowed to select a PCP at the time of enrollment and may change their PCP voluntarily at any time by contacting Member Services. For involuntary termination of a PCP, please see the Non-Compliant members/PCP Transfer in Practitioner/Provider Responsibilities and Important Information chapter.

PCP Selection

Primary care practitioners include practitioners in the following specialties:

- Family practice,
- General practice,
- Internal Medicine or
- Pediatrics

Every family member enrolled in the Plan must choose a primary care practitioner, although it does not have to be the same physician. All members have the option of changing their primary care practitioner. Members may request to change their PCP following the initial visit without cause. PCP change requests are made effective immediately.

- Aetna Better Health members are given the opportunity to select a Primary Care Practitioner (PCP).
- If a member has NOT selected a PCP upon enrollment, Aetna Better Health shall assign one for them. Aetna Better Health shall consider factors such as age, gender, language(s) spoken, location, and special needs.
- Upon notice of the current automatically assigned PCP by Aetna Better Health, the member has the opportunity to request a PCP change if not satisfied with the assigned PCP.
- A list of PCPs is made available to all Aetna Better Health members. Member Service representatives are available to assist members with selecting a PCP.
- Members have the freedom to select participating PCPs based on age/gender limit restrictions.
- Members are encouraged to choose a PCP that is geographically convenient to them; however, members are not restricted by any geographic location.

Members may change their PCP at any time, by contacting Member Services at **1-888-348-2922**.

Members with a disabling condition and/or chronic illness may request that their PCP be a specialist. These requests will be reviewed by the Aetna Better Health Medical Director to ensure that the specialist requested agrees to accept the role of PCP and assume all the responsibilities associated with this role. Members need to contact Member Services directly for such requests. Member Services will route the request directly to the Medical Director for review.

We may initiate a change in a member's primary care practitioner under the following circumstances:

- The member's primary care practitioner ceases to participate in Aetna Better Health's network.
- The practitioner/patient relationship will not work to the satisfaction of either the practitioner or the patient.
- The practitioner requests the patient select another primary care practitioner and sends written notification to the member and to Aetna Better Health, giving a minimum of 30-day notice.

New members are encouraged to schedule an appointment with their PCP within 30 calendar days of initial enrollment.

Members are advised to get to know and maintain a relationship with their primary care practitioner. They are instructed to always contact their primary care practitioner before obtaining specialty services or going to the emergency room. It is the responsibility of all primary care practitioners to manage the care of each patient, directing the patient to specialty care services as necessary. It is the responsibility of the specialist practitioner to work closely with the primary care practitioner in the process.

Member Disenrollment from Aetna Better Health

The West Virginia Bureau for Medical Services (BMS) has sole authority for dis-enrolling members. BMS may dis-enroll members for any of the following reasons:

- Loss of eligibility
- Placement of the member in a long-term nursing facility, state institution or intermediate care facility for the intellectually disabled for more than 30 days
- Member selection of a different Medicaid or WV CHIP Managed Care Plan
- Member change of residence outside of our service area
- Profound noncompliance of a member to follow prescribed treatments or requirements that are consistent with state and federal laws and regulations when agreed upon by the BMS
- Abuse of the system, threatening or abusive conduct/behavior that is disruptive and unruly which seriously impairs Aetna Better Health ability to provide service to either the member or others
- Commitment of intentional acts to defraud Aetna Better Health and/or BMS for covered services

New Member Information

Educational and informational materials are frequently sent to our members. Aetna Better Health members are sent a welcome packet upon enrollment. The welcome packet contains the following:

- Welcome letter
- Instructions to access the member handbook
- New member welcome book
-
- EPSDT information
- Notice of Privacy Practices which contains Aetna Better Health protocols relative to ensuring member privacy of records

Member identification cards are sent separately via first class mail service prior to the mailing of a new member welcome packet. Aetna Better Health identification cards indicate the PCP's name and telephone number.

Beneficiaries must sign a Medical Release of Information Form when they enroll with the West Virginia Medicaid or CHIP Program. This release authorizes the release of medical records to us and any representative of Aetna Better Health to promote:

- Continuity of care
- Assist in the coordination of care
- Clinical review
- State and Federal sponsored audit
- Accreditation Agency

Member Outreach Activities

The Aetna Better Health Member Outreach Department, Quality Management and Care Management are responsible for contacting members to assist with coordinating gaps in care. The Member Outreach Department frequently coordinates activities within the community to provide member education and information regarding Aetna Better Health member initiatives.

Advance Directives

Please see the Practitioner/Provider Responsibilities and Important Information chapter for additional information.

Member Complaint and Appeal Process

Members have the right to file a grievance (complaint) or dispute an adverse determination (appeal). Aetna Better Health asks that all practitioners and providers cooperate and comply with all Aetna, State of West Virginia, and/or CMS requirements regarding the processing of member complaints and appeals, including the obligation to provide information within the timeframe reasonably requested for such purpose.

The following information about complaints and appeals is provided to all members in the Member Handbook:

Complaints/Grievances

As a member of Aetna Better Health, you have the right to file a complaint at any time. You can file a complaint (also called a grievance) if you are unhappy with something about Aetna Better Health or one of our practitioners or providers You can also file a complaint if you disagree with our decision about your appeal. To file an informal complaint, call us at **1-888-348-2922** to let us know that you are unhappy with Aetna Better Health or your health care services. You can also call your Case Manager to help you.

You can also take steps to file a formal (written) complaint or allow someone like your PCP to do so on your behalf. If someone files a complaint on your behalf, we will need your OK in writing.

To file a written complaint, you will need to send us a letter that has:

- Your name
- Provider/Practitioner name, if about a service
- Date of service, if your complaint is about a service
- Your mailing addresses
- The reason you are filing the complaint and what you want Aetna Better Health to do.
- Any information or additional documents that could support your case

Please mail it to:

Aetna Better Health of West Virginia
PO Box 81139
5801 Postal Rd
Cleveland, OH 44181

We will acknowledge receipt of your complaint in writing within 3 calendar days from when we receive it. We will usually get our response to you within 90 calendar days from the date your complaint is received. If it is in your best interest, you can ask for a delay in our decision for up to 14 calendar days. If we need to delay our decision for another reason, we will give you written notice within two calendar days.

If you need help with a complaint, you can call Member Services toll-free at **1-888-348-2922**. We can assist you in completing forms. We also offer interpreter services or assistance for your vision or hearing preferences such as auxiliary aids, and other services.

Appeals

As a member of Aetna Better Health, you have the right to appeal a decision, including a non-coverage decision. You can file an appeal for many reasons, such as if you do not agree with our decision about your service authorization or prior authorization request. Appeals can be filed verbally or in writing. Our decision to reduce, suspend, or stop services will be sent to you in a Notice of Action letter. You will have 60 calendar days from the date of the Notice of Action to file an appeal with Aetna Better Health. If you would like your benefits to continue while the appeal is pending, you or your practitioner/provider must file a request within 13 calendar days of the date of the Notice of Action letter. If our appeal decision is not in your favor, you may have to pay for services you received while the appeal was pending.

You can file an appeal by calling Member Services at **1-888-348-2922** (TTY: **711**) or you can do so in writing. If you choose to write to us, you will need to include your address. You can have someone else file an appeal on your behalf, such as your PCP, a lawyer or a family member. We just need your OK in writing.

To file a written appeal, please mail it to:
Aetna Better Health of West Virginia
PO Box 81139
5801 Postal Rd
Cleveland, OH 44181

Aetna Better Health will respond to your appeal within 30 calendar days from the day your appeal is received. If it is in your best interest, you can ask for a delay in our decision for up to 14 calendar days. If we need to delay our decision for another reason, we will give you written notice within two calendar days. For appeals that need to be resolved more quickly, we will give you our decision within 72 hours after receiving your appeal. You may have to pay the cost of services, depending on the outcome.

If you need help with an appeal, you can call Member Services toll-free at **1-888-348-2922**. We can assist you in completing forms. We also offer interpreter services or assistance for your vision or hearing preferences such as auxiliary aids, and other services.

Fair Hearings

As a member of Aetna Better Health, you have the right to request a state fair hearing. You can only request a state fair hearing after you have received notice that Aetna Better Health is upholding the decision to reduce, suspend, or stop your benefits. You must request the state fair hearing no later than 120 calendar days from the date of our decision notice. It is our job to mail you the form and give you the information you need.

Once you get the form, please mail it back to:

WV Bureau for Medical Services
Attn: Office of Medicaid Managed Care
350 Capitol Street, Room 251
Charleston, WV 25301

If you would like your benefits to continue while the hearing is going on, you or your practitioner or provider must file a request within 13 calendar days. You may have to pay the cost of services, depending on the outcome. Parties to the state fair hearing can include the State, Aetna Better Health, your representative, or the representative of a deceased member. The State will hear your case and decide within 90 days of your request for a state fair hearing.

Please call Member Services at **1-888-348-2922** if you have questions about requesting a state fair hearing. You can also call the Department of Health and Human Resources at **304-558-0684**.

Member Handbook

A member handbook is provided to our actively enrolled members upon enrollment and annually thereafter. Changes to any program or any service site changes are provided to members in a timely manner. The member handbook includes information about covered and non-covered services and covers key topics such as: how to choose and change a PCP, copays, and guidance to emergency care. The member handbook is available electronically on our website.

Chapter 8 - Care Management

The purpose of Care Management is to identify, assess, and provide intervention in cases that due to their chronicity, severity, complexity, and/or cost, require close management to affect an optimal member outcome in a cost-effective manner. Our Care Management referrals come from a variety of sources including our predictive modeling engine's Consolidated Outreach and Risk Evaluation (CORE) tool, claims, health risk questionnaires, care management assessments, concurrent review/prior authorization referrals, discharge planner referrals, as well as member, care giver and practitioner or provider referrals. The Case Manager will review medical management/utilization management data such as, but not limited to, specific high-risk diagnosis, multiple admissions or ER visits, length of stay admissions greater than seven (7) days, and/or multiple disciplines/therapies required for a treatment.

After receiving referral, the Care Management staff will then request information to assess the member's current medical status through questionnaires telephonically and/or face to face. The Case Manager will collaborate with specialty consultants, attending physician, the PCP, the member, the member's "family," and other members of the health care team in order to facilitate the highest quality of service, at the most cost-effective level, that support the goals established to achieve the member's best long-term outcome. The Case Manager will attempt to identify and direct the use of alternative resources within the community that serve to support achieving established goals in the event a benefit is not available.

Aetna Better Health utilizes an Integrated Care Management Program which is designed to identify our most bio-psychosocially complex and vulnerable members with who we have an opportunity to make a significant difference. We engage these members in our program to remove or lessen barriers that limit their ability to manage their own health, educate them about their chronic conditions and help them remain in the least restrictive and most integrated environment based on their preferences, needs, safety, burden of illness and availability of family and other supports.

The integrated program addresses the member's medical, behavioral and social needs in an integrated fashion. Case Managers assist members in coordinating medical and/or behavioral health services as well as those available in the community and/or that are not covered in the Member's benefits package.

The Case Manager serves as a liaison for practitioners, providers, members, family, caregiver, state workers, and/or alternate payers to ensure compliance to the treatment plan, facilitate the appropriate use of cost-effective alternative services, as well as assess effectiveness of the treatment plan based on goals achieved.

For members under the Mountain Health Trust and CHIP benefit, cases will be considered closed upon the termination of the member, refusal of the member or family to participate with the care management process or if the member is unable to be reached by the Case Manager following multiple outreach attempts. If the physician and/or member agree that the reassessment, current treatment plan and/or progress of the member is such that care management intervention is no longer required to maintain the member at his/her optimum level of wellness the case may also be closed. Members of the Mountain Health Trust and CHIP benefit have the right to opt out of the program at any time. Members of Mountain Health Promise are not able to opt out unless they are adopted care members or youth formerly in foster care who aged out of foster care while enrolled in WV Medicaid. Members who are not adopted or have not aged out receive contractually required outreaches from the Case Management staff.

To refer a member for care management support, practitioners and providers may contact us at **1-888-348-2922**.

Aetna Better Health implements a population-based approach to specific chronic diseases or conditions. All Aetna Better Health members with identified conditions are auto enrolled in the program based on claims data. Members that do not wish to participate can call member services and notify the health plan of their desire not to participate and they will be dis-enrolled from the program. All enrollees are sent educational material to promote better member understanding of the disease or condition affecting them. Information also addresses self-care, appropriate medical care, and testing which are supported by evidence-based practices and tools. Additionally, auto-alert flags to the Case Manager's desktop identify members with significant "gaps" in their care and/or disease/condition education. Case Managers reach out to those members in an effort to educate and assist the members in obtaining needed services, including, lifestyle modifications and health resource access.

Members receive information about all population health management programs through various communication sources such as member handbook, member newsletter and postings on the website. The population health management programs for Aetna Better Health are as follows: Healthy Adults/Healthy Kids, Healthy Pregnancies/Healthy Babies, Flu Vaccination Program, Living with Diabetes, Moms and Babies (Neonatal Abstinence), Appropriate Use of Acute Care Settings, Opioid Management, ER Utilization, Managing Diabetes and Heart Disease, Chronic Condition Management Program and the Child and Family Welfare Program. These programs focus on keeping members healthy, managing members with emerging risks, patient safety and outcomes across settings and managing multiple chronic conditions.

Our goal is to assist our members, your patients, to better understand their chronic conditions, update them with new information and provide them with assistance from our staff to help them manage their disease. Practitioners and providers can contact the Plan at **1-888-348-2922** and follow the prompts to enroll a member in our Care Management program. The chronic conditions managed include diabetes, COPD, asthma, CAD, depression and heart failure.

Our staff are regionalized throughout the state of West Virginia allowing us to meet our members in the communities where they live. Aetna Better Health also works with several practitioners/providers throughout the state by having a Case Manager onsite to meet with members. This partnership helps build relationships between the practitioner/provider, member and payer promoting better health outcomes for the member.

The following services are offered by the Care Management program:

- Support from health plan nurses and other health care staff to ensure that patients understand how to best manage their condition and periodically evaluate their health status,
- Periodic newsletters to keep them informed of the latest information on conditions and their management,
- Educational and informational materials that assist members in understanding and managing medications prescribed by practitioners, how to effectively plan for visits to see practitioners and reminders as to when those visits should occur

Membership in our care management program is voluntary, which means at any time members can request withdrawal from the program, they need only call the health plan's Member Services department.

Chapter 9 – Concurrent Review

Aetna Better Health conducts concurrent utilization review on each member admitted to an inpatient facility, including freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the Hearst Corporation's MCG evidence-based care guidelines (formerly Milliman Care Guidelines). Admission certification is conducted within 72 hours of receiving the request for authorization.

Continued stay reviews are conducted before the expiration of the assigned length of stay. Practitioners and providers will be notified of approval or denial of additional days. The nurses work with the medical directors in reviewing medical record documentation for hospitalized members.

Medical Criteria

To support inpatient concurrent review decisions, Aetna Better Health uses nationally recognized, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Concurrent review staff that make medical necessity determinations is trained on the criteria. These criteria are established and reviewed according to Aetna Better Health policies and procedures.

Criteria sets are reviewed annually for appropriateness to the Aetna Better Health's population needs and updated as applicable when national guidelines are updated. The annual review process involves appropriate practitioners and providers in developing, adopting, or reviewing criteria. The criteria are consistently applied, considering individual needs of the members and allow for consultations with requesting practitioners/providers when appropriate. These are to be consulted in the order listed. For inpatient medical care reviews, Aetna Better Health uses the following medical review criteria:

- Criteria required by applicable state or federal regulatory agency
- Aetna Medicaid Pharmacy Guidelines
- MCG (physical health and behavioral health)
- Level of Care Utilization System (LOCUS), Child & Adolescent Level of Care Utilization System (CALOCUS)
- American Society of Addiction Medicine Criteria (ASAM)
- Aetna Clinical Policy Bulletins (CPB's)
- Aetna Clinical Policy Council Review
- Other Specialty Criteria by contract and approved by committee

A free copy of individual criteria is available upon request by calling phone **1-888-348-2922**.

If you would like to discuss a case or have more information, you can call one of our medical directors at **1-833-459-1998**. The request for peer-to-peer review must be received within 2 business days of the issuance of the verbal denial, independent of the discharge date.

Discharge Planning Coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the member and for involving the member and family in implementing the plan.

Our Concurrent Review Nurse (CRN) works with the hospital discharge team and attending physicians to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning.
- Facilitating discharge planning for members with complex and/or multiple discharge needs.
- Providing hospital staff and attending physician with names of network practitioners or providers (i.e., home health agencies, DME/medical supply companies, other outpatient practitioners or providers).
- Informing hospital staff and attending physician of covered benefits as indicated.

Chapter 10 – Prior Authorization

The requesting practitioner or provider is responsible for complying with Aetna Better Health's prior authorization requirements, policies, request procedures, and for obtaining an authorization to facilitate reimbursement of claims. We will not prohibit or otherwise restrict a practitioner, acting within the lawful scope of practice, from advising, or advocating on behalf of a member of Aetna Better Health about their health status, medical care, or treatment options (including any alternative treatments that may be self-administered). This may include the provision of sufficient information to provide an opportunity for the member to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Medical Criteria

To support prior authorization decisions, Aetna Better Health uses nationally recognized, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Prior authorization staff that make medical necessity determinations is trained on the criteria. These criteria are established and reviewed according to Aetna Better Health policies and procedures.

Criteria sets are reviewed annually for appropriateness to the Aetna Better Health's population needs and updated as applicable when national guidelines are updated. The annual review process involves appropriate practitioners and providers in developing, adopting, or reviewing criteria. The criteria are consistently applied, considering individual needs of the members, and allow for consultations with requesting practitioners/providers when appropriate. For prior authorization of elective inpatient, outpatient medical services and pharmaceuticals, Aetna Better Health uses the following medical review criteria in the order listed:

- Criteria required by applicable state or federal regulatory agency
- Aetna Medicaid Pharmacy Guidelines
- MCG (physical health and behavioral health)
- Level of Care Utilization System (LOCUS), Child & Adolescent Level of Care Utilization System (CALOCUS)
- American Society of Addiction Medicine Criteria (ASAM)
- Aetna Clinical Policy Bulletins (CPBs)
- Aetna Clinical Policy Council Review
- Other Specialty Criteria by contract and approved by committee

Note that coverage is excluded for procedures, treatments and devices that are determined to be experimental or investigational.

A free copy of individual criteria is available upon request by calling **1-888-348-2922.**

If you would like to discuss a case or have more information, you can call one of our medical directors at **1-833-459-1998.** The request for peer-to-peer review must be received within 5 business days of the date the denial of coverage determination fax was sent.

Elective hospital admissions and some outpatient surgical procedures require prior authorization. Contacting our prior authorization department prior to scheduling elective services may minimize any scheduling, network access, benefit availability, and/or medical necessity issues during the prior authorization process. At a minimum, the request for services must be made 3 business days prior to the date of service to promote a timely determination. All late notifications of elective admissions or outpatient surgical procedures are subject to denial based on lack of timely notification.

Access to Our Utilization Management Team

The UM staff is available to discuss specific cases or UM questions by phone between 8:30 AM and 5 PM by calling **1-844-835-4930**; TTY **711**. UM Staff can receive inbound communication on holidays and weekends by voice mail and fax. The ability to receive faxed information is available 24 hours per day, 7 days per week at **1-866-366-7008**. Staff will identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. Members who need language assistance can call member services at the number on the back of their ID card.

Practitioners and providers may call **1-844-835-4930** to request prior authorization, and these requests must include the following:

- Current, applicable codes (may include):
  - Current Procedural Terminology (CPT),
  - International Classification of Diseases, 10th Edition (ICD-10),
  - Centers for Medicare and Medicaid Services (CMS) Common Procedure Coding System (HCPCS) codes
- Name, date of birth, and identification number of the member
- Name, address, phone and fax number of the treating practitioner
- Problem/diagnosis, including the ICD-10 code
- Presentation of supporting objective clinical information, such as:
  - Clinical notes
  - Laboratory and imaging studies
  - Prior treatments

All clinical information should be submitted with the original request. If the codes on an authorization that has been obtained change or if additional codes need to be added, the practitioner/provider has 10 days to notify Aetna Better Health of those changes.

Timeliness of Decisions and Notifications to Practitioners, Providers and/or Members

Aetna Better Health makes prior authorization decisions and notifies practitioners and/or providers and applicable members in a timely manner. Unless otherwise required by BMS, we adhere to the following decision/notification time standards.

Decision	Decision timeframe	Notification to	Notification method
Urgent pre-service approval	Based on members need but no more than 2 calendar days from receipt of request	Practitioner/Provider	Electronic/Written
Urgent pre-service denial	Based on members need but no more than 2 calendar days from receipt of request	Practitioner/Provider and Enrollee	Electronic/Written
Non-urgent pre-service approval	Based on members need but no more than 7 calendar days from receipt of the request. This 7 calendar days period may be extended up to 14 additional calendar days upon request of the enrollee or provider, or if we justify to BMS in advance and in writing that the enrollee will benefit from such extension.	Practitioner/Provider	Electronic/Written
Non-urgent pre-service denial	Based on members need but no more than 7 calendar days from receipt of the request. This 7 calendar days period may be extended up to 14 additional calendar days upon request of the enrollee or provider, or if we justify to BMS in advance and in writing that the enrollee will benefit from such extension.	Practitioner/Provider and Enrollee	Written

If Aetna Better Health approves a request for urgent determination, a notification will be sent to the physician involved, as appropriate, of its determination as expeditiously as the member's health condition requires, but no later than 2 calendar days after receiving the request. This two (2) calendar day period may be extended up to forty-eight (48) hours for expedited prior authorizations and up to seventy-two (72) hours for expedited concurrent reviews upon request of the enrollee or if the MCO justifies to BMS in advance and in writing a need for additional information and that the enrollee will benefit from such extension.

A request is considered urgent when a 7-calendar day non-urgent prior authorization could seriously jeopardize the life or health of a member, the member's ability to attain, maintain or regain maximum function, or that a delay in treatment would subject the member to severe pain that could not be adequately managed without the care/service requested.

Out-of-network Practitioners/Providers

When approving or denying a service from an out-of-network practitioner or provider, Aetna Better Health sends documentation of the approval or denial to the requesting practitioner or provider within the time frames appropriate to the type of request.

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

For authorized non-emergency and non-authorized emergency out-of-network services, Aetna Better Health will reimburse at 80% of the Medicaid or CHIP fee-for-service rate.

Prior Authorization List

The treating practitioner or provider must request authorization for certain medically necessary services.
A list of services that require prior authorization can be found at **AetnaBetterHealth.com/WestVirginia**. This list is not intended to be all inclusive. For any questions call Prior Authorization at **1-844-835-4930.** Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment.

Prior Authorization and Coordination of Benefits

If another insurance is the primary payer before Aetna Better Health, the prior authorization determination from the primary insurance will be honored. If the service is not covered by the primary payer or the member has exhausted the primary payer benefit limits,the practitioner or provider must follow our prior authorization rules.

How to Request Prior Authorizations

A prior authorization request may be submitted by:

- Using our 24/7 Secure Provider Web Portal located on our website
- Faxing the request form to **1-866-366-7008** (forms are available on the health plan website)
    - Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing,
- Calling Prior Authorization directly at **1-844-835-4930**

Chapter 11 – Quality Management

Aetna Better Health's Quality Management program is designed to continuously improve and monitor the medical care, member safety, behavioral health services, and the delivery of services to members, including ongoing assessment of program standards to determine the quality, accessibility and appropriateness of care, care management and coordination. A key focus of our quality program is improving the member's biological, psychological and social well-being with an emphasis on quality of care and the non-clinical aspects of all services. Where the member's condition is not amenable to improvement, our goal is to maintain the member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. Incorporating the continuous quality improvement (CQI) concept, our quality program is comprehensive and integrated throughout Aetna Better Health and the practitioner/provider network. We promote the integration of our quality management activities with other systems, processes, and programs throughout Aetna Better Health.

Quality Management is a company-wide endeavor, with crosscutting teams who work together to integrate by interdepartmental monitoring processes and activities (such as those for referring quality of care/risk issues, member/practitioner complaints, complaints and appeals), business application systems and databases that are accessible to all areas. Our quality program also includes a structure of oversight committees with representation not only from across West Virginia, but from the practitioner and provider network and member population as well.

Program Purpose

The Aetna Better Health QM Program allows Aetna Better Health the flexibility to target activities that focus on patterns identified at the local market level. The QM Program provides a structure for promoting and achieving excellence in all areas through continuous improvement. It provides the framework for Aetna Better Health to continually monitor, evaluate and improve the quality of care, safety and services provided to all members, employers, practitioner and providers and external/internal customers. The program provides an ongoing evaluation process that lends itself to improving identified opportunities for under/over utilization of services. Core values of the program include maintaining respect and diversity for members, practitioners, providers and employees.

We use practitioner/provider performance data to help improve the quality of service and clinical care our members receive. Accrediting agencies require that you let us use your performance data for this purpose.

The QM program is a commitment to innovation, affordability, professional competence and continuous learning, teamwork and collaboration. The clinical aspects of the QM Program are structured from evidence-based medicine. The QM Program also ensures health services needs of members, including those with limited English proficiency and diverse cultural and ethnic backgrounds are met. The QM Program supports efforts to attain an understanding of the populations served, in terms of age groups, disease categories and special risk status through analysis, monitoring and the evaluation of processes. The quality of care and services are optimized and continuously improved while maintaining cost effective utilization of health care resources. This is accomplished by systematic monitoring and evaluation of provided services and by actively pursuing opportunities for improvement. The program addresses activities related to QM, utilization management (UM), customer service, member rights and responsibilities, member experience, practitioner/provider credentialing and re-credentialing, risk management and delegation vendor/entity oversight.

The QM Program promotes member compliance with recommended preventive health services. Standards are set and monitoring is done to ensure these services remain a focus. Preventive health care remains the key to the attainment of improved member health and satisfaction and a cost-effective health plan. Members are educated about age specific preventive care.

The process of Utilization Management plays a vital role in the QM program including, but not limited to, concurrent review and prior authorization programs, identification of potential quality of care issues and potential under and over- utilization.

The QM Program consists of the following elements:

- QM Program Description Summary
- Policies & Procedures
- Annual QM Program Evaluation
- Annual QM Work Plan
- Quality Improvement Activities
- QM Committee Structure

Employees must avoid situations where their personal interest could conflict or appear to conflict with their responsibilities, obligations or duties to the health plan's interest or present an opportunity for personal gain apart from the normal compensation provided through employment. Aetna Better Health does not make specific payment, either directly or indirectly, to a physician or physician group as an inducement to reduce or limit Medically Necessary covered services furnished to any enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future. Utilization management decision making is based only on appropriateness of care and service and existence of coverage. Aetna does not specifically reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization. No reviewing physician may perform a review on one of his/her patients, or cases in which the reviewing physician has a proprietary financial interest in the site providing care. If an issue should arise where inappropriate incentives are suspected to have been paid, the issue will be referred to the Special Investigations Unit (SIU) for review and recommendation.

It is our policy to conduct business in a manner that protects the privacy of our members. Confidentiality will be maintained in accordance with federal and state laws. Confidential information requested, used and disclosed in the course of an investigation, is limited to the minimum amount necessary to accomplish the intended purpose; and controlled to maintain confidentiality and to minimize Health plan access to a "need to know" basis.

All committee minutes and reports are considered confidential. All external committee members are required to sign a confidentiality and conflict of interest statement prior to serving on a committee. All Health plan employees sign a confidentiality agreement as a condition of employment and receive annual training on HIPAA and confidentiality policies.

Aetna Better Health's Quality Management program goals are to:

- Promote collaboration among our departments and systems to allow for the collection and sharing of quality management data and monitoring of outcomes
- Work in collaboration with practitioners and providers to actively improve the quality of care provided to members
- Maintain compliance with federal and state regulatory requirements and consistency with the State's quality strategy/quality plan and all other requirements of the contract
- Evaluate identified quality, risk and utilization issues, and develop follow-up measures (including action plans) to resolve the issues and prevent recurrences
- Define criteria for measuring clinical and non-clinical performance and assessing the outcomes against established standards and benchmarks, including HEDIS® measures
- Assess and identify opportunities for improvement by performing quality management and performance improvement activities as requested by internal and external customers (including regulatory agencies). This assessment process will ideally be based on solid data and focused on high volume/high risk procedures or other services that promise to substantially improve quality of care, using current practice guidelines and professional practice standards when comparing to the care provided
- Identify, monitor and evaluate high-volume, problem-prone or high-risk aspects of health care and service
- Provide feedback to members and their family/representative and/or caregiver, advocates, practitioners, providers and Aetna Better Health staff
- Maintain mechanisms for reviewing the entire range of care delivery systems, including all demographic groups, care settings, and services available to the member (e.g., annual population assessment)
- Monitor the practitioner and provider network's capacity to accommodate the diverse needs of the member population, including special health care needs as well as specific language or cultural needs and

preferences. The evaluation of access includes analysis of services to members with physical and mental disabilities.
- Monitor outpatient and inpatient services to identify deviations from standard of care/service
- Identify opportunities to educate members and their family/representative and or caregiver, advocates, practitioners, providers, and Aetna Better Health staff about quality management and performance improvement activities and outcomes and ways to improve members' health
- Develop, maintain, and increase awareness of prevention and wellness and outreach programs available to members (to include programs addressing chronic and catastrophic illness, behavioral health, long term care and care management)
- Incorporate an awareness of member safety into all quality activities
- Maintain technical business information systems to support quality management and performance improvement activities and improve them as necessary to meet program needs
- Inform members and practitioners of members' rights and responsibilities

Our objectives in the administration of our quality management program are to:
- Act on identified opportunities for improving health care outcomes for members and monitor for continued effectiveness
- Educate practitioners and providers and members and their family/representative and/or caregiver on appropriate and efficient utilization of health care services and facilities
- Maintain systems for monitoring and tracking practitioner and provider quality management and performance improvement trends and medical record keeping practices
- Maintain integrated processes to support quality management and performance improvement activities
- Manage quality and risk management referrals in order to promote optimum quality of care and service
- Evaluate practitioner and ancillary provider quality and utilization management and take action to improve areas showing opportunities for improvement
- Credential and recredential practitioners and other network providers in a thorough and timely manner, in accordance with State and NCQA standards
- Inform and educate members and their family/representative and/or caregiver, practitioners, providers, and other stakeholders about quality and health improvement programs in order to increase the utilization of preventive health care, care management and other services
- Monitor and evaluate the continuity, availability, and accessibility of care or services provided to members
- Compile practitioner and provider information (such as quality or risk management trends, outcomes, and other information) into practitioner and provider information files
- Provide feedback to members and their family/representative and/or caregiver, practitioners and providers on the success of quality management and performance improvement activities, including health outcomes
- Improve the satisfaction of members, practitioners and providers with health care delivery
- Assist members with navigating the health care delivery system
- Establish standards of clinical care and service utilizing objective criteria and processes to evaluate and continually monitor for improvement
- Develop and maintain integrated systems and processes for collecting and disseminating quality data and information
- Integrate oversight of practitioner/provider quality and utilization management and act if needed to promote improvement
- Promote involvement of members and their family/representative and/or caregiver and practitioners in the quality management program and related activities by encouraging feedback (e.g., through member/practitioner/provider satisfaction surveys, telephone calls, participation on committees, as applicable)

Patient Safety

Aetna has a patient safety program in place which is intended to support practitioners and providers (e.g., hospitals, home health agencies, skilled nursing facilities, freestanding surgical centers, behavioral health facilities), in their efforts to monitor for and reduce the incidence of medical errors. The program may include one or more of the following: prescription drug utilization review and tracking and trending of adverse events; analysis of procedure and/or diagnosis codes to identify opportunities for improvement in medical practices and communicate any findings directly to the practitioner and/or provider involved; and education of practitioners, providers and members about prevention and detection of unsafe practices.

Governing Body

The Aetna Better Health Board of Directors has delegated ultimate accountability for the management of the quality of clinical care and service provided to members to the Chief Medical Officer (CMO). The CMO is responsible for providing national strategic direction and oversight of the QM Program for Aetna Better Health members. The Board of Directors delegates responsibility of the health plan quality improvement process to the Quality Management Oversight Committee (QMOC) which oversees the quality program.

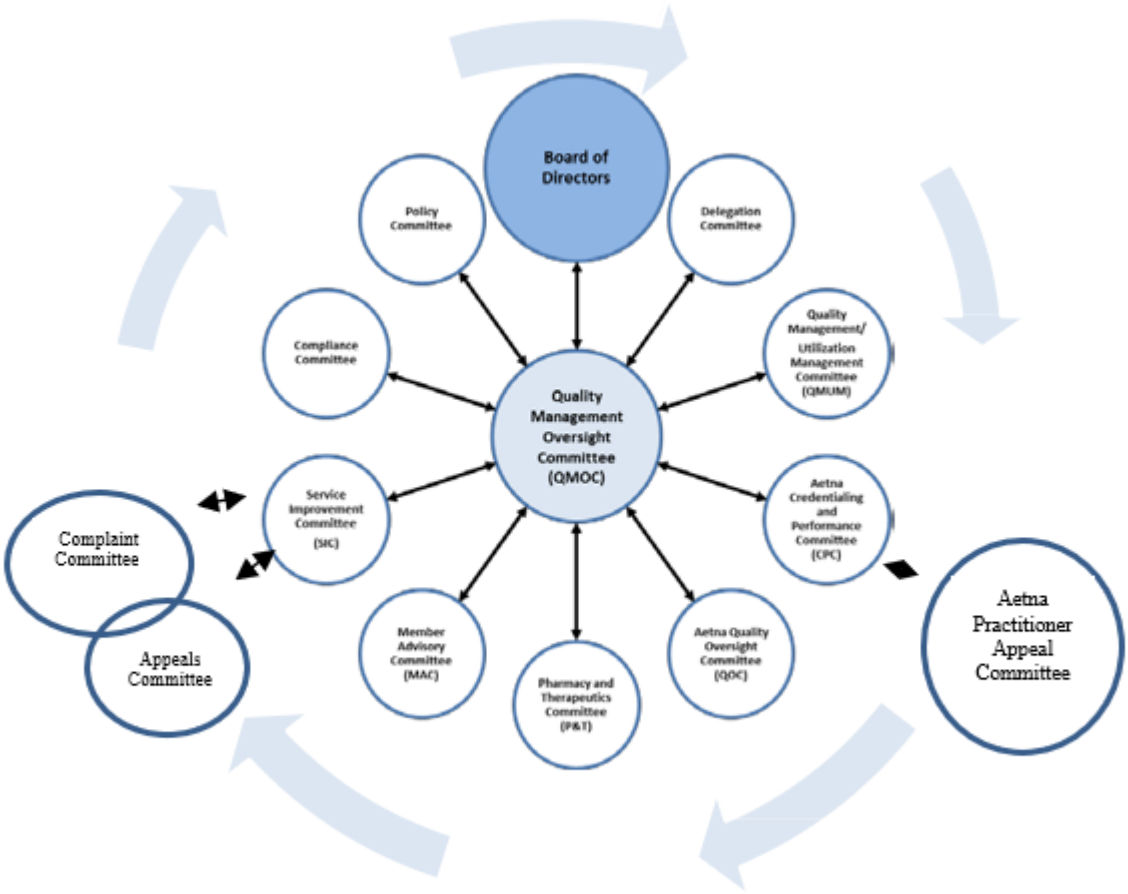
Program Accountability – Board of Directors

Aetna Better Health Board of Directors has ultimate accountability for the Quality Assessment Performance Improvement (QAPI) Program and related processes, activities, and systems. This includes responsibility for implementing systems and processes for monitoring and evaluating the care and services members receive through the health delivery network. The chief executive officer on behalf of the Quality Management Oversight Committee submits the QAPI Program Description and any subsequent revisions to the board of directors for approval. In addition, the chief executive officer annually submits to the board of directors an evaluation of the previous year's QAPI activities, summary reports, data, outcomes of studies and credentialing activities (i.e., annual evaluation). The proposed annual QAPI work plan is also submitted to the board of directors for approval. After evaluating the information, the board of directors may provide further direction and recommendations to the Chief Executive Officer for enhancements to the QAPI and work plan.

Committee structure

Quality management and performance improvement activities are reported to the board of directors through the following committees:

- Quality Management Oversight Committee (QMOC)
- Quality Management/Utilization Management Committee (QM/UM)
- Delegation Committee
- Aetna Credentialing and Performance Committee (CPC)
  - Aetna Practitioner Appeal Committee (PAC)
- Aetna Quality Oversight Committee (QOC)
- Service Improvement Committee (SIC)
  - Complaint Committee
  - Appeals Committee
- Member Advisory Committee (MAC)
- Compliance Committee (CC)



Quality Management Oversight Committee (QMOC)

The Quality Management Oversight Committee's primary purpose is to integrate quality management and performance improvement activities throughout the health plan and the practitioner and provider network. The committee is designated to provide executive oversight of the QAPI and make recommendations to the board of directors about Aetna Better Health's Quality Management and performance improvement activities, including the annual QAPI, work plan and evaluation and work to make sure the QAPI is integrated throughout the organization, and among departments, delegated organizations and network practitioners and providers.

Quality Management/Utilization Management Committee (QM/UM Committee)

The Quality Management/Utilization Management (QM/UM) Committee's primary purpose is to advise and make recommendations to the Chief Medical Officer on matters pertaining to the quality of care and service provided to members including the oversight and maintenance of the QAPI and utilization management program. Summary reports are submitted to the Quality Management Oversight Committee for review/approval and board of directors.

Delegation Committee

Aetna Better Health does not delegate QAPI activities. Aetna Better Health may delegate limited health plan activities. The Delegation Committee advises and makes recommendations to the QMOC about delegated relationships.

Aetna Credentialing and Performance Committee (CPC)

The Aetna Better Health Quality Management Oversight Committee (QMOC) has delegated decision-making authority to the Aetna Credentialing and Performance Committee's (CPC). This committee is responsible for credentialing and recredentialing individual practitioners who deliver services to members. This committee is also responsible for conducting professional review activities involving the practitioner and providers whose professional competence or conduct adversely affects or could adversely affect the health or welfare of members.

Aetna Practitioner Appeals Committee (PAC) - Subcommittee to CPC

The purpose of the Aetna Practitioner Appeals Committee (PAC) is to conduct professional review hearings of practitioners and providers who appeal decisions made by the Aetna Credentialing and Performance Committee involving professional competence or conduct of the practitioner or provider. The committee, which is, facilitated by an Aetna medical director, consists of practitioners who are appointed on an ad hoc basis by the Aetna Credentialing and Performance Committee. The committee reports through CPC and to the Aetna Better Health QMOC.

Aetna Quality Oversight Committee (QOC)

The Aetna Better Health Quality Management Oversight Committee (QMOC) has delegated authority to the Aetna Quality Oversight Committee (QOC) to conduct the credentialing/recredentialing of facilities/organizational providers/vendors and the review of facilities/organizational providers/vendors potential quality of care issues and complaints.

Service Improvement Committee

The Service Improvement Committee advises and makes recommendations to the Quality Management Oversight Committee and/or Aetna Better Health management about customer (member and practitioner/provider) issues.

Complaint Committee

The Complaint Committee reviews issues of expression of dissatisfaction by members, including complaints.

Appeals Committee

The Appeals Committee reviews and issues decisions on appeals that are filed by members, or practitioners and providers on behalf of members.

Member Advisory Committee (MAC)

The Member Advisory Committee (MAC) provides feedback to Aetna Better Health regarding strategies for improving member care and services; including health education and other member materials.

Compliance Committee (CC)

The Compliance Committee (CC) reviews, monitors and assesses the effectiveness of Aetna Better Health compliance plan.

Policy Committee (PC)

The Policy Committee purpose is to provide a forum for the consistent development, implementation, approval and communication of all Aetna Better Health policies.

Member Profiling

Member profiles play a pivotal role in the management of member care both by Aetna Better Health's integrated care management team, as well as by the member's medical home/PCP. Member profiles are used to:

- Identify members who have under-or-over utilized health services, including emergency department services, hospital admissions and prescribed medications, and could benefit from integrated care management services
- Identify members who may lack appropriate access to needed services or could benefit from education about how to best utilize the health care system (e.g., persons with high emergency room utilization, or lack of preventive service utilization)
- Identify medical homes/PCPs that do not appear to be following recommended clinical practice guidelines or need to reach out to their assigned members more effectively and facilitate better management of the member's care
- Assist in supporting other internal health plan operations, such as concurrent review decisions, member appeals, and fraud and abuse detection

Practitioner/Provider Profiles

Aetna Better Health uses the practitioner or provider profile to monitor a practitioner's or provider's utilization practices along with members' health outcomes to identify opportunities for improvement. The objectives of the practitioner or provider profiles are to identify utilization patterns that vary significantly from peer network practitioner/provider groups; identify trends that can be addressed through outreach; provide information to network practitioners or providers about their practice patterns; safeguard confidentiality by maintaining secure access to the profile interface;

provide information to be used as a component of quality management oversight; and provide information to be used as a component of practitioner or provider incentive compensation.

Member, Practitioner and Provider Satisfaction Surveys

Member, practitioner and provider satisfaction with health care services is assessed to discover areas that are working well and identify opportunities for improvement. Member surveys are conducted by an Aetna Better Health approved vendor using nationally standardized survey items. Additional focused surveys of specific populations or users of identified services may be conducted at the discretion of the Chief Executive Officer. Member surveys include but are not limited to questions related to availability and accessibility of healthcare, practitioners, utilization, quality of care and service, quality of member services, requests to change practitioners and/or sites, and cultural competency. Practitioner or provider surveys address satisfaction with Aetna Better Health's utilization management procedures (prior authorization, concurrent review), claims processing, and Aetna Better Health's response to inquiries.

When areas for potential improvement are identified from member, practitioner or provider surveys or other sources (such as member complaints, complaints/appeals or PIPs), Aetna Better Health uses a formal process to evaluate the areas identified. The identified issues are prioritized, and the concerns addressed, interventions are implemented, and the issue is reassessed to determine change and satisfaction.

Clinical Practice Guidelines

Aetna Better Health uses evidence-based clinical practice guidelines. The guidelines consider the needs of enrollees, opportunities for improvement identified through our QM Program, and feedback from participating practitioners and providers. Guidelines are updated as appropriate, but at least every two years. The Clinical Practice Guidelines and Preventive Health Guidelines are located on our website.

HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that the public has the information it needs to reliably compare performance of managed health care plans. Aetna Better Health collects this data annually.

Why do health plans collect HEDIS data?

The collection and reporting of HEDIS data are required by the Center for Medicare and Medicaid Services (CMS). Accrediting bodies such as the National Committee for Quality Assurance (NCQA), along with many states, require that health plans report HEDIS data. The HEDIS measures are related to many significant public health issues such as cancer, heart disease, asthma, diabetes and utilization of preventive health services. This information is used to identify opportunities for quality improvement for the health plan and to measure the effectiveness of those quality improvement efforts.

How are HEDIS measures generated?

HEDIS measures can be generated using three different data collection methodologies:

- Administrative (uses claims and encounter data)
- Hybrid (uses medical record review on a sample of members along with claims and encounter data)
- Survey

Why does the plan need to review medical records when it has claims data for each encounter?

Medical record review is an important part of the HEDIS data collection process. The medical record contains information such as lab values, blood pressure readings and results of tests that may not be available in claims/encounter data. Typically, a plan employee will call the physician's office to schedule an appointment for the chart review. If there are only a few charts to be reviewed, the plan may ask the practitioner or provider to fax or mail the specific information.

How accurate is the HEDIS data reported by the plans?

HEDIS results are subjected to a rigorous review by certified HEDIS auditors. Auditors review a sample of all medical record audits performed by the health plan, so the plan may ask for copies of records for audit purposes. Plans also monitor the quality and inter-rater reliability of their reviewers to ensure the reliability of the information reported.

Is patient consent required to share HEDIS related data with the plan?

The HIPAA Privacy Rule permits a practitioner or provider to disclose protected health information to the health plan for the quality related health care operations of the health plan, including HEDIS, provided the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 CFR 164.506 (c) (4). Thus, a practitioner or provider may disclose protected health information to a health plan for the plan's HEDIS purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.

May the practitioner or provider bill the plan for providing copies of records for HEDIS?

According to the terms of their contract, practitioners and providers may not bill either the plan or the member for copies of medical records related to HEDIS.

How can practitioners and providers reduce the burden of the HEDIS data collection process?

We recognize that it is in the best interest of both the practitioner/provider and the plan to collect HEDIS data in the most efficient way possible. Options for reducing this burden include providing the plan remote access to electronic medical records (EMRs) and setting up electronic data exchange from the practitioner/provider EMP to the plan. Please contact a provider relations representative or the QM department for more information. Complete and accurate coding as well as submitting secondary payer claims can significantly reduce the number of charts needed to review.

How can practitioners or providers obtain the results of medical record reviews?

The plan's QM department can share the results of the medical record reviews performed at practitioner or provider offices and show how results compare to that of the plan overall. Please contact a provider relations representative or the QM department for more information.

Chapter 12 – Encounters, Billing and Claims

Aetna Better Health processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable state and federal laws, rules and regulations. We will not pay claims submitted by a practitioner/provider who is excluded from participation by the State of West Virginia.

Aetna Better Health uses the Trizetto QNXT® system to process and adjudicate claims. Both electronic and paper claims submissions are accepted. To assist us in processing and paying claims efficiently, accurately and timely, the health plan highly encourages practitioners and providers to submit claims electronically, when possible. To facilitate electronic claims submissions, we have developed a business relationship with Emdeon. Aetna Better Health receives EDI claims directly from this clearinghouse, processes them through pre-import edits to maintain the validity of the data, HIPAA compliance and member enrollment and then uploads them into QNXT each business day. Within 24 hours of file receipt, we provide production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

When to Bill a Member

All practitioners or providers are prohibited from billing any member beyond the member's cost sharing liability, if applicable, as defined on the Aetna Better Health's remittance advice.

When to File a Claim

All claims and encounters with Aetna Better Health members must be reported to us, including prepaid services.

Request for Notes/Invoices

Certain procedures may require the submission of additional documentation before payment is made. In cases of this nature, the claim will be closed, and we will request notes or an invoice. Practitioners and providers must then submit notes or an invoice in order for the claim to be reviewed. These must be submitted within 1) 120 days of the date of the request or, 2) the original timely filing period applicable to the claim as described below or the claim will be denied for timely filing.

Timely Filing

In accordance with contractual obligations, claims for services provided to a member must be received in a timely manner. Our timely filing limitations are as follows:

- New Claim Submissions – Claims must be filed on a valid claim form within 365 days from the date services were performed (unless there is a contractual exception). For hospital inpatient claims, date of service means the date of discharge of the member.
- Practitioners/Providers have 365 days from the date of the primary remittance advice to submit a Coordination of Benefits (COB) Claim. This applies to new claim submissions only. If the claim is submitted and denied for the primary remittance advice, the claim resubmission timeframe of 120 days from the date of the original remittance from the health plan will apply.
- Claim Resubmission – Claim resubmissions must be filed within 120 days from the date of original remittance advice from the health plan. Please submit any additional documentation that may effectuate a different outcome or decision.
- Practitioners/Providers have 120 from the date of original remittance advice from the health plan for reconsiderations.

Failure to submit accurate and complete claims within the prescribed time period may result in payment delay and/or denial.

How to File a Claim

1) Select the appropriate claim form:
   a. Medical and professional services use current version of the CMS 1500 Health Insurance Claim Form.
   b. Hospital inpatient, outpatient, skilled nursing and emergency room services use UB-04.
   c. Rural Health Clinics and Federally Qualified Health Centers use UB-04 or CMS 1500, as appropriate for the services rendered. Please contact Provider Relations with additional questions.
2) Complete the claim form
   a. Claims must be legible and suitable for imaging for record retention. Complete ALL required fields and include additional documentation when necessary
   b. The claim form may be returned unprocessed (unaccepted) if illegible or poor-quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.
3) Submit claims electronically or original copies through the mail (faxed claims are not routinely accepted).
   a. Payer ID: 128WV
   b. Electronic Clearing House – Practitioners and providers who are contracted with us can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent, and minimizes clerical data entry errors. Additionally, a Level Two report is provided to vendors, which is the only accepted proof of timely filing for electronic claims.
      - Emdeon is the EDI vendor we use.
      - Contact the software vendor directly for further questions about electronic billing.
      - Contact our Provider Services Department for more information about electronic billing.
4) Through the mail
   a. To include supporting documentation, such as enrollees' medical records, clearly label and send to us at the following address: **Aetna Better Health of West Virginia**
   P.O. Box 982965
   El Paso, TX 79998-2965

- Corrected claims must be clearly identified as a resubmission by stamping/writing "corrected claim" or "resubmission" on the paper claim form.
- Altered claims must be clearly initialed at the correction site. Initialing corrections ensures the integrity of a corrected claim.
- Corrected claims must include all original claim lines, including those previously paid correctly. Resubmitted claims without all original claim lines may result in the recoupment of correct payments.
- Dates of service on the claim should fall within the prior authorized service date range. Including dates of services outside the authorized range may result in denials.
- Claims for services requiring an authorization should include the authorization number in block 23 on the CMS-1500 form and block 63 on UB-04 forms or in the appropriate field on EDI claims.
- The authorization number should not contain any pre-fixes or suffixes such as "R12345," "#7890," or "3456 by Laura."
- Claims must have current, valid, and appropriate ICD diagnosis codes.
- The diagnosis codes must be coded to the highest degree of specificity to be considered valid.
- Claims must be submitted with valid CPT, HCPCS and/or revenue codes.
- Claims submitted with nonstandard CPT, HCPCS, revenue codes or modifiers will NOT be processed and will be returned to the practitioner or provider. These claims should be reworked and submitted timely to the initial claims address.
- Each CPT or HCPCS code line must have a valid place of service (POS) (block 24B) code when billing on a CMS-1500 form.
- Accident details should be provided when applicable (Block 10B of CMS-1500 Form).
- List all other health insurance coverage when applicable (Block 9A-D of CMS-1500 Form).
- Practitioners and Providers must submit the appropriate NPI numbers in Block 33A of the CMS-1500 and Block 56 of the UB-04.
- Billing practitioner or provider taxonomy information should be submitted (Block 33B of the CMS-1500 form)

All practitioners and providers, including FQHCs and RHCs, must submit their claims listing out their usual and customary charges as the billed amounts on the applicable claim form.

NDC Requirements

Federal regulations require States and Managed Care Organizations (MCOs) to collect NDC numbers from practitioners and providers on claims for the purposes of billing manufacturers for drug rebates. As a result, practitioners and providers will not be reimbursed for drugs unless a valid 11-digit NDC number, Unit of Measure and quantity administered are reported on the UB 04 or CMS 1500 claims.

A complete NDC data set consists of:

- An 11 Digit National Drug Code (NDC) Number
- Unit of Measure code
- F2-International Unit
- GR-Gram
- ML-Milliliter
- UN-Unit
- ME-Milligrams
- If the NDC data set is missing, incomplete, or invalid, Aetna Better Health will deny the affected claim line.

Encounter Claims and Other Electronic Data Submission

We submit all claims related information to DHHR monthly. We must ensure that all electronic data submitted to the DHHR are timely, accurate and complete. An encounter is any service received by the Aetna Better Health member and paid for by us. We submit encounters/claims for all services it covers, including, but not limited to, inpatient and outpatient procedures, EPSDT screens, durable medical equipment (DME), and home health services. Due to this requirement, we request that all practitioners and providers follow our filing procedures set forth below.

A process is available for reconsideration of claims denied for failure to file within the deadline. Information, including copies of claims and documentation of previous filing(s) supporting the request, should be sent to:

Aetna Better Health of West Virginia
Attn: Claims Department
P.O. Box 982965
El Paso, TX 79998-2965

Social Determinants of Health

A number of Medicaid enrollees experience a disparate level of social needs such as transportation, housing, food access, unemployment, or education level. Aetna Better Health encourages billing of ICD-10 Z-codes where appropriate to collect data so that Aetna Better Health may assist these members in obtaining the necessary services.

Paper billing

CMS 1500 Paper Claims (professional):

- Box 33 - Billing Practitioner or Provider Physical Address
- Box 33A - Billing Practitioner or Provider NPI
- Box 33B - Billing practitioner or provider taxonomy
  - Enter the 2-digit qualifier of “ZZ” followed by the taxonomy code
  - Do not enter a space, hyphen, or other separator between the qualifier and number (e.g. ZZ207Q00000X)
- Box 24J - Rendering NPI - (bottom of box, non-shaded area)
- UB-04 Paper Claims (institutional):
- Billing Practitioner or Provider NPI submitted in field 56, top row
- Billing practitioner or provider taxonomy submitted in field 81
  - Enter the 2-digit qualifier of “B3” in the first column and then the taxonomy code immediately following

If there are questions regarding this information, please contact Provider Services.

Multiple Procedures

Multiple procedures performed on the same day and/or at the same session are processed at 100% of the contracted rate for the primary procedure, 50% of the contracted amount for the secondary procedure and 50% of the

contracted amount for any subsequent procedures; or as defined by a practitioner's or provider's current contract with Aetna Better Health or State of West Virginia guideline changes.

Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Aetna Better Health can request copies of operative reports or office notes to verify services provided. Certain modifiers may affect payment amounts as defined by the State of West Virginia Medicaid or CHIP Fee Schedule or contract with Aetna Better Health. Common modifier issue clarification is below:

- Modifier 59 – Distinct Procedural Services - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 - 77499).
- Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.
- Modifier 50 – Bilateral Procedure - If no code exists that identifies a bilateral service as bilateral, a practitioner or provider may bill the component code with modifier 50. Services should each be billed on one-line reporting one unit with a 50 modifier.
- Modifier 57 – Decision for Surgery – must be attached to an Evaluation and Management code when a decision for surgery has been made. We follow CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period.

Please refer to the Current Procedural Terminology (CPT) Manual for further detail on proper modifier usage.

Correct Coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Incorrect Coding

Examples of incorrect coding include:

- "Unbundling" - Fragmenting one service into components and coding each as if it were a separate service or `billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

Correct Coding Initiative

Aetna Better Health utilizes claims editing systems designed to evaluate the appropriate billing information and CPT coding accuracy on procedures submitted for reimbursement. Our edit guidelines are based on, but not limited to: NCCI, CPT-4, HCPCS and ICD coding definitions, AMA and CMS guidelines, specialty edits, pharmaceutical recommendations, industry standards medical policy and literature research input from academic affiliations.

The major areas of reviews are:

- Procedure Unbundling - Billing two or more individual CPT codes to report a procedure when a single more comprehensive code exists that accurately describes the procedure.
- Incidental Procedures - A procedure that is performed at the same time as a more complex procedure, however, the procedure requires little additional physician resources and/or is clinically integral to the performance of the

primary procedure.
- Mutually Exclusive Procedures - Two or more procedures that are billed, by medical practice standards, should not be performed or billed for the same patient on the same date of service.
- Multiple Surgical Procedures - Surgical procedures are ranked according to clinical intensity and paid following percentage guidelines.
- Duplicate Procedures - Procedures that are billed more than once on a date of service.
- Assistant Surgeon Utilization - Determination of reimbursement and coverage.
- Evaluation and Management Service Billing - Review the billing for services in conjunction with procedures performed.

When reviewing a remittance advice, any CPT code that has been changed or denied by the editing system will be noted by the appropriate disposition code. These types of denials are not appealable or disputable and any request by the provider for review should come through the reconsideration process.

Submission of Itemized Billing Statements

We may require that Practitioners or Providers submit an Itemized Billing Statement along with their original claims. Claims billed in excess of $50,000.00 require an Itemized Billing Statement. If an Itemized Billing Statement is required, the claim will be denied for an Itemized Billing Statement if one is not supplied. The Itemized Billing Statement must be submitted within 120 days of the original claim denial date

Balance Billing

Aetna Better Health participating Practitioners or Providers are prohibited, by contract, from billing members for any balance of payment other than co-pays for covered services, or as otherwise permitted under applicable law. Practitioners and Providers accept reimbursement from Aetna Better Health in full.

A Practitioner or Provider may seek reimbursement from a member when a service is not a covered benefit and the member has given informed written consent before treatment that they agree to be held responsible for all charges associated with the service.

If a member reports that a Practitioner or Provider is balance billing for a covered service, the practitioner or provider will be contacted by one of our Member Services representatives to research the complaint. If the issue remains unresolved, the practitioner or provider will be contacted by an Aetna Better Health Provider Relations Representative. Aetna Better Health is obligated to notify BMS when a Practitioner or Provider continues the inappropriate practice of balance billing a member.

Coordination of Benefits (COB)

By law, Medicaid is the payer of last resort. Aetna Better Health, as an agency of the State of West Virginia is considered the payer of last resort when other coverage for a member is identified. Aetna Better Health shall be used as a source of payment for covered services only after all other sources of payment have been exhausted.

COB claims must be received by Aetna Better Health within 365 days from the member's primary carrier remittance advice date. A copy of the primary carrier RA and disposition detail must accompany the claim.

Aetna Better Health pursues Third Party Liability (TPL) claims based on requirements and/or limitations under our contract with the State of West Virginia.

Participating and/or non-participating Practitioners and Providers are required to follow Aetna Better Health's policies on authorization requirements even when Aetna is not the primary payer.

Other General Claims Instructions

Aetna Better Health claims are paid in accordance with the terms outlined in the participation contract for this product.

Clean claims are paid within 30 days of receipt. The date of receipt is specified as the date Aetna Better Health receives the claim, as indicated by its date stamp (including electronic) on the claim, and date of payment as the date of the check release or other form of payment release to the provider. For in network providers, clean claims not paid within 30 days are subject to payment of 18% per annum, calculated daily for the full period in which the

clean claim remains unpaid beyond the 30-day clean claims payment deadline.

Home Health Care

Practitioners and providers submitting claims for Home Health should use CMS 1500 Form. Practitioners and providers must bill in accordance with their contract and/or State of West Virginia guidelines.

Durable Medical Equipment (DME)

Providers submitting claims for DME Rental should use CMS 1500 Form. DME rental claims are only paid up to the purchase price of the durable medical equipment.

Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to ensure proper tracking and posting of adjustments. We recommend that practitioners and providers keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Call Provider Services for more information about electronic remittance advice.

An electronic version of the Remittance Advice can be obtained. In order to qualify for an Electronic Remittance Advice (ERA), a practitioner/provider must currently submit claims through EDI and receive payment for claim by EFT. Practitioners and providers must also have the ability to receive ERA through an 835 file. We encourage our practitioners and providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for practitioners and providers to receive payment and reconcile outstanding accounts. Please contact our Provider Services Department for assistance with this process.

Checking Status of Claims

Practitioners and Providers may check the status of a claim by accessing our secure provider portal website or by calling Claims Inquiry and Claims Research.

- Online Status through Aetna Better Health's Secure Provider Portal Website
  - We encourage practitioners and providers to take advantage of using online status, as it is quick, convenient and can be used to determine status for multiple claims.
- Claims Inquiry and Claims Research can:
  - Answer questions about claims
  - Assist in resolving problems or issues with a claim
  - Provide an explanation of the claim adjudication process
  - Help track the disposition of a particular claim
  - Correct errors in claims processing

Corrected Claims and Resubmissions

Practitioners and Providers have 120 days from the date of the original remittance advice from the health plan to resubmit a corrected version of a processed claim. Practitioners and providers may resubmit a claim that was originally denied because of missing documentation, incorrect coding, etc.

Please submit the Resubmission Form located on our website along with:

- An updated copy of the claim. All lines must be rebilled; even lines which paid appropriately on initial submission.
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction. Please remember corrections must be made on the claim form.
- Clearly label as "Resubmission" or "Corrected Claim" at the top of the claim in black ink and mail to appropriate claims address.

Failure to mail and accurately label the resubmission to the correct address may cause the claim to deny as a duplicate.

A resubmission should be submitted to the following address:

Aetna Better Health
Attn: Claims Department
P.O. Box 982965
El Paso, TX 79998-2965

Claim Reconsiderations

Practitioners and Providers have 120 days from the date of the original remittance advice from the health plan to submit a reconsideration. Practitioners and providers may submit a reconsideration for claims that were originally denied due to claim editing.

Please submit the Reconsideration Form located on our website along with:

- An updated copy of the claim. All lines must be rebilled; even lines which paid appropriately on initial submission.
- Any additional documentation required.
- A brief note describing review requested. Please remember any corrections to diagnosis codes, modifiers or CPT/HCPCS codes must be made on the claim form.
- Clearly label as "Reconsideration" at the top of the claim in black ink and mail to appropriate claims address.

Failure to mail and accurately label the reconsideration to the correct address may cause the claim to deny as a duplicate.

A reconsideration can be submitted to the following address or uploaded in the Provider Portal:

Aetna Better Health
Attn: Claims Department
P.O. Box 982965
El Paso, TX 79998-2965

Claim Disputes

Practitioners and Providers have 120 days from the initial remittance date to dispute claims. Practitioners and providers may dispute a claim that they believe was paid at the incorrect rate or denied because of processing errors. Disputes may not be submitted on claims that denied due to claim editing.

A dispute should be submitted with the Provider Claim Dispute Form (available on the Aetna Better Health of West Virginia website) to the following address:

Aetna Better Health
Attn: Claim Disputes
500 Virginia St East Suite 400
Charleston, WV 25301

Examples of dispute requests:

- Contract interpretation issues
- Participating practitioner or provider claim processed as non-participating in error

Timely Filing Denials

It is the responsibility of the practitioner or provider to maintain their account receivables records, and Aetna Better Health of West Virginia recommends that practitioners and providers perform reviews and follow-up of their account receivables on at least a monthly basis to determine outstanding Aetna Better Health claims. Aetna Better Health of West Virginia will not be responsible for claims that were received outside timely filing limits.

Recognizing that practitioners and providers may encounter timely filing claims denials from time to time, we maintain a process to coordinate review of all disputed timely filing claim denials brought to our attention by practitioners or providers. If a claim is denied for timely filing, complete the Provider Claim Dispute Form available on the Aetna Better Health's website and attach proof of timely filing.

Electronic Submission

Electronic claim submission (EDI) reports are available from each practitioner's or provider's claims clearinghouse after each EDI submission. These reports detail the claims that were sent to and received by Aetna Better Health. Practitioners and providers must submit a copy of the acceptance report from the practitioner's or provider's respective clearinghouse that indicates the claim was accepted by Aetna Better Health within timely filing limits to override timely filing denial and pay the claim.

Please confirm that the claim did not appear on a rejection report. If Aetna determines the original claim submission was rejected, the claim denial will be upheld and communicated in writing to the practitioner or provider.

Paper Submission

Practitioners and providers must submit a screen print from their respective billing system or database with documentation that shows the claim was generated and submitted to Aetna Better Health within the timely filing limits.

Documentation should include:

1. The system printout that indicates:
    a. Claim was submitted to Aetna Better Health
    b. Name and ID number of the member
    c. Date of service
    d. Date the claim was filed to Aetna Better Health
2. A copy of the original CMS-1500 or UB-04 claim form that shows the original date of submission

Remittance Advice

We generate checks weekly. The Remittance Advice (remit) is the notification to the practitioner or provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the practitioner or provider participates. Claims processed during a payment cycle will appear on a remittance advice as paid, denied, or reversed. Information provided on the remit includes:

- Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- Remit Date represents the end of the payment cycle.
- Beginning Balance represents any funds still owed to Aetna Better Health for previous overpayments not yet recouped or funds advanced.
- Processed Amount is the total of the amount processed for each claim represented on the remit.
- Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the participation contract.
- Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- Refund Amount represents funds that the practitioner or provider has returned to Aetna Better Health due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of REVERSED in the claim detail header with a non-zero Refund Amount listed.
- Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- Ending Balance represents any funds still owed to Aetna Better Health after this payment cycle. This will result in a negative Amount Paid.
- Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the EFT Reference # and EFT Amount are listed along with the last four digits of the bank account, the funds were transferred. There are separate checks and remits for each line of business in which the practitioner or provider participates.
- Benefit Plan refers to the line of business applicable for this remit. TIN refers to the tax identification number.
- Claim Header area of the remit lists information pertinent to the entire claim. This includes:

- Member Name
- Member ID number
- Practitioner or Provider Name
- Claim Status
- Date of Birth
- Account Number
- Authorization ID, if obtained
- Claim Number
- Refund Amount, if applicable

- Claim Totals are totals of the amounts listed for each line item of that claim.
- Code/Description area lists the processing messages for the claim.
- Remit Totals are the total amounts of all claims processed during this payment cycle.
- Message at the end of the remit contains claims inquiry and resubmission information as well as complaint rights information.

Refund of Overpayment

If a provider believes that a claim has been overpaid, they should report the overpayment by submitting the refund, along with a letter detailing the reason for the refund to:

Aetna Better Health of West Virginia-FINANCE
P.O. BOX 842684
Dallas, TX 75284-2684

Reimbursement Rates

In the case of provider reimbursement that is tied to the Medicaid or CHIP fee-for-service rate schedule, Aetna Better Health is required to implement any rate changes adopted by BMS within 30 calendar days of notification of the rate change. Aetna Better Health must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. Aetna Better Health must reprocess any claims paid between the notification date and the system load date to the updated rate.

Aetna Better Health supports a value-based health care system where member experience and population health are improved, the trajectory of health care cost is contained through aligned incentives with managed care organization and provider partners, and there is a commitment to continuous quality improvement and learning. To support this effort, Aetna Better Health is actively working to design and implement payment models with network providers that tie reimbursement to measurable outcomes. APMs may include, but are not limited to the following:

1. Primary care incentives.
2. Payment for performance.
3. Shared savings arrangements.
4. Risk sharing arrangements.
5. Episodes of care/bundled payments; and
6. Capitation Payments with Performance and Quality Requirements.

Aetna Better Health reports annually to BMS on APM activity including a description of initiatives, goals and outcomes measured for the contract year, description of the monitoring activities, evaluation of effectiveness of previous year's initiatives, summary of lessons learned and implemented changes. Descriptions of significant barriers and plans for the next year are also included.

Chapter 13 – Inquiry, Complaint and Appeals

Aetna Better Health has an Inquiry, Complaint, and Appeals process for members, practitioners and providers to dispute a claim authorization or an Aetna Better Health decision. This includes both administrative and clinical decisions of Aetna Better Health. A practitioner or provider has 90 days, and a member has 60 days from the Notice of Action to file an Appeal (which must be done in writing) and 60 days to file a Complaint, which may be done in writing or by calling Member Services. Members have a one-level internal appeal process through Aetna Better Health. See Chapter 7 for a description of the member complaint and appeal process.

There are no punitive actions to members, practitioners or providers for filing a complaint or appeal. Members, practitioners and providers have the right to submit written comments with all levels of the process.

Practitioner or Provider Inquiries and Complaints

In order to ensure a high level of satisfaction, Aetna Better Health provides a mechanism for Practitioners or Providers to express dissatisfaction with Plan decisions. Practitioners or Providers may express questions or dissatisfactions through our Provider Inquiry and Complaints Process.

If a practitioner or provider has questions regarding member benefits/eligibility, claim status/payment, remittance advices, authorization inquires, etc. please access the provider portal or contact Claims Inquiry and Claims Research (CICR). Inquiries are handled daily and are normally resolved on the initial contact.

To submit a dissatisfaction regarding an issue with Aetna Better Health, you may contact Provider Services at **1-888-348-2922**. Complaints received will be documented and forwarded to appropriate personnel for resolution. The resolution will be documented within our internal system and conveyed to the complainant.

After following these steps, if you are a participating provider, and still dissatisfied you may have the right to file an appeal. Please refer to the Appeals section below for instructions on filing an appeal. Members, Practitioners and Providers have the right to request and receive a written copy of Aetna Better Health utilization management criteria, in cases where the Appeals are related to a clinical decision/denial.

Claim Reconsideration vs. Claim Appeal

Aetna Better Health has two separate and distinct processes designed to assist practitioners and providers with issue resolution. The chart below illustrates the process to follow when filing a claim reconsideration versus an appeal.

	Reconsideration	**Appeal**
Form (available online)	Reconsideration Form	Appeal form
Address	Aetna Better Health Attn: Claims Department P.O. Box 982965 El Paso, TX 79998-2965	Aetna Better Health of West Virginia PO Box 81040 5801 Postal Rd Cleveland, OH 44181
Appropriate Categories	1) Claims editing denials 2) Medical records requested for review	1) Denied days for IP (inpatient) stays 2) Authorization denials for late notification 3) Claim denial for no authorization/ pre-certification/ medical necessity not met 4) Services denied per finding of a review organization
Timeframe	120 days from the date of denial	90 days of the date of denial

Practitioner/Provider Appeal of Claim Action

Practitioners or Providers may appeal an adverse claim action. Prior to appealing a claim action, practitioners or providers should contact Claims Inquiry/Claims Research (CICR) for claim information. In many cases, claim denials are the result of inaccurate filing practices. Please follow the filing practices listed in the above sections as well as the steps below, in order to minimize claims issues:

- Contact Claims Inquiry and Claims Research at **1-888-348-2922** as the first step is to clarify any denials or other actions relevant to the claim. A representative will be able to assist a practitioner or provider with a possible resubmission of a claim with modifications or reconsideration.
- If an issue is not resolved after speaking with Aetna representatives and is related to one of the appealable reasons listed above, the practitioner or provider may challenge actions of a claim denial or adjudication by filing a formal appeal with the Aetna Better Health Appeals Department.
    - o the appeal must be filed in writing and must specifically state the factual and legal basis for the appeal, including a chronology of pertinent events and a statement as to why the practitioner or provider believes the action by Aetna Better Health was incorrect.
    - O Practitioners and Providers must attach copies of any supporting documents, such as claims, remittance advices, medical records, correspondence, etc. If additional copies of medical records are requested for appeal consideration, such copies are created at the practitioner's or provider's expense.
- Appeals should state Formal Practitioner or Provider Appeal on the document(s) and should be mailed to:

    Aetna Better Health of West Virginia
    PO Box 81040
    5801Postal Rd
    Cleveland, OH 44181

Examples of appeals:

- Denied as not medically necessary
- If a cosmetic denial is upheld and would like it reviewed a second time
- Timely filing
- Denied for no authorization

Tips to Writing an Effective Appeal

If a practitioner or provider does not agree with our decision regarding requested services or benefit coverage, we have provided tips to writing an effective complaint or appeal letter:

- Include the name, address, and a phone number where the appealer can be reached in case there are any questions
- Include the patients name, date of birth, and insurance I.D. number
- Describe the service or item being requested
- Address issues raised in our denial letter
- Address the medical necessity of the requested service
- Include information about the patient's medical history:
    - o Prior treatments
    - o Surgery Date
    - o Complications
    - o Medical condition and diagnosis

If applicable to an appeal situation, please also provide:

- Any unique patient factors that may influence our decision
- Why alternate methods or treatments are not effective or available
- The expected outcome and/or functional improvement
- An explanation of the referral to an Out-of-Network practitioner/provider

When submitting an appeal, be sure to provide the necessary information to describe the patient, treatment, and expected outcomes as described above.

Expedited Appeal Requests

Expedited requests are available for members only for circumstances when application of the standard Appeal time frames would seriously jeopardize the life or health of the member or the member's ability to attain, maintain or regain maximum function. This option only available pre-service and if a provider files an expedited appeal requests for a service it will be considered an appeal on behalf of the member and follow the member appeal process. A verbal request indicating the need for an expedited review should be made directly to Prior Authorization at **1-844-835-4930**. Those requests for an expedited review that meet the above criteria will have determinations made within seventy-two (72) hours or earlier as the member's physical or mental health requires.

Process definitions and determination timeframes

Process	Definition	Determination
Inquiry	Any question from a practitioner or provider regarding issues such as benefits information, claim status, or eligibility.	Ten working days from receipt of the Inquiry
Complaint	A complaint is any expression of dissatisfaction expressed by a practitioner or provider regarding an issue in the Health Plan. If a practitioner or provider is dissatisfied with any issue regarding the Health Plan, the practitioner or provider may contact the respective Customer Service Departments at the number(s) listed above. Complaints must be received within 90 calendar days of the date of the incident that gave rise to the complaint.	Within 30 calendar days of receipt of the complaint
Appeal	An appeal is a request by the practitioner or provider when the resolution of a complaint is not resolved to the practitioner's or provider's satisfaction and the practitioner or provider appeals the Health Plan's decision within the prescribed time frames. Examples: a denial or a limited authorization of a requested service, including the type or level of service, that the service is determined to be experimental, investigational, cosmetic, not medically necessary or inappropriate. The Appeal must be received within 90 calendar days after the date of the Health Plan's Notice of Action.	72 hours from receipt of the Expedited Appeal; within 30 calendar days from receipt of the standard Appeal request

Written inquires and complaints can be mailed to:	Written appeals can be mailed to:
Aetna Better Health of West Virginia Attn: Inquiries PO Box 81040 5801 Postal Rd Cleveland, OH 44181	Aetna Better Health of West Virginia Attn: Appeals Coordinator PO Box 81040 5801 Postal Rd Cleveland, OH 44181

Fraud, Waste and Abuse

Aetna Better Health will not tolerate health care fraud, waste or abuse in any of its relationships with either internal or external stakeholders. Aetna Better Health will identify, report, monitor, and, when appropriate, refer for prosecution situations in which suspected fraud, waste or abuse occurs.

Managed care fraud is defined as the intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some payment or unauthorized benefit to himself and some other person. This includes any act that constitutes fraud under applicable Federal or State law.

Managed care waste is defined as the rendering of unnecessary, redundant, or inappropriate services and medical errors and incorrect claim submissions. Generally, not considered criminally negligent actions, managed care waste is rather the misuse of resources and involves taxpayers not receiving reasonable value for their money in connection with any government-funded activities due to inappropriate act or omission by players with control over or access to government resources. Waste goes beyond fraud and abuse and most waste does not involve a violation of law; it relates primarily to mismanagement, inappropriate action and inadequate oversight.

Managed care abuse is defined as practitioner or provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs to the 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 enrollee practices that result in unnecessary costs to the Plan, Federal or State programs. To report fraud, waste and abuse, please contact the Compliance, Fraud, Waste, and Abuse line at **1-844-405-2016**.

Aetna Better Health follows a mandatory corporate compliance plan that incorporates annual employee training, system controls, data mining tools, internal auditing and a designated Special Investigations Unit (SIU) to monitor, detect, investigate and report potential fraud, waste and abuse. All Aetna staff complete required training in identifying potential fraud, waste and abuse and are provided the tools, upon hire and annually thereafter, for reporting questionable situations. Training includes how to detect and prevent member, practitioner, provider and employee fraud, waste and abuse. Additionally, the Member Services staff receives thorough training for fraud, waste and abuse. At Aetna, our goal is to operate at the highest level of ethical standards.

The Special Investigations Unit (SIU) detects and investigates cases of potential health care fraud, waste and abuse. This includes cases of potential fraud, waste and abuse by subcontractors of Aetna Better Health. Examples of fraud and abuse include but are not limited to the following:

- Submitting a Claim for services not furnished either by using genuine patient information to fabricate entire Claims or by padding Claims with charges for procedures or services that did not take place.
- Submitting a Claim with inaccurate diagnosis or procedure codes with the intent of maximizing payments or obtaining Coverage that the member is not entitled to.
- Submitting a Claim knowing reimbursement has previously been remitted.
- Misrepresenting dates of services, description of service, or identity of member, Practitioner or Provider in order to obtain reimbursement to which the Practitioner, Provider or member is not entitled.
- Submitting a Claim for Non-Covered Services in a manner that categorizes them as Covered Services.
- Submitting a Claim for a more costly service than the one actually performed, commonly known as “upcoding” – i.e., falsely billing for a higher-priced treatment than was actually provided (which often requires the accompanying “inflation” of the patient’s diagnosis code to a more serious condition consistent with the false procedure code);
- Submitting unbundled Claim(s) for the purpose of avoiding these Claim policies and procedures.

The SIU utilizes state-of-the-art data analysis tools to detect irregularities which could be indicators of possible fraud, waste, and abuse. Clinical Investigators and experienced fraud, waste and abuse investigators work collaboratively to conduct investigations identified through various sources.

The SIU reviews medical claims on a prospective and retrospective basis using sophisticated data mining technology tools to identify and investigate unusual or inappropriate billing patterns. This could lead to some claims being denied for supporting medical documentation. The SIU also may request supporting documentation or schedule an on-site audit to investigate previously paid claims. The investigation does not mean that a practitioner or provider is practicing fraud. In many cases, the SIU finds the billing practice was in error. In all cases, the SIU will work with the appropriate Provider Relations representative to communicate what is believed an inappropriate billing practice.

If a Practitioner, Provider or member is suspected of fraud, waste or abuse, an investigation begins, an audit is performed, and the member, Practitioner or Provider is referred to our Program Integrity Committee for review. When appropriate and an investigation and audit is warranted, those cases are reported to external entities, i.e., including but not limited to the Center for Medicare and Medicaid Services, the West Virginia Department of Health and Human Services Office of Inspector General, and the Bureau for Medical Services. Reports include the name and ID number of the party involved, the source of the complaint, the practitioner or provider type, nature of the complaint, approximate dollar amount involved and the legal and administrative status of the case.

Our credentialing process for contracted practitioners and providers includes a verification that the practitioner or provider is eligible to participate. We specifically check the Excluded Provider Database on the HHS OIG Web site to confirm the practitioner or provider has not been debarred or otherwise sanctioned or excluded by Medicare, Medicaid or SCHIP. This information is also requested on the credentialing and re-credentialing application.

Aetna Better Health contract provisions with participating practitioners and providers specifically state, that they shall not employ or contract for the provision of health care, utilization review, medical social work or administrative services with any individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. The practitioner or provider hereby certifies that no such excluded person currently is employed by or under contract with them or with any “downstream” entity with which they contract relating to the furnishing of these services to Aetna Better Health members.

Our Credentialing Verification Center conducts ongoing monitoring of the HHS OIG and State Professional Registration boards internet sites. Any information found pertaining to participating Aetna Better Health practitioners and providers are referred for review by the credentialing committee to ensure compliance.

Our delegated credentialing entities are required to verify that the practitioners and providers with whom they contract are eligible to participate, including checking the HHS OIG Web site to confirm the practitioner or provider has not been debarred or otherwise sanctioned or excluded by Medicare, Medicaid or CHIP. Part of our ongoing evaluation of the delegated entities is confirmation of ongoing monitoring of state and federal web sites to identify current sanctions or complaints.

As required by the Deficit Reduction Act of 2005, it is Aetna Better Health’s policy to provide detailed information to Aetna Better Health employees, vendors or other subcontractors, and other persons acting on behalf of Aetna Better Health, about the Federal False Claims Act, administrative remedies for false claims and statements established under 31 U.S.C 3801 et seq., and applicable State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws (collectively, “False Claims Acts”). The False Claims Acts assist the Federal and State Government in preventing and detecting fraud, waste and abuse in Federal health care programs, such as Medicare and Medicaid.

Attachments section

Attachment A:	Claim Inquiry/Adjustment Request Form
Attachment B:	Provider Change in Information Form
Attachment C:	Quick Reference Guide
Attachment D:	Behavioral Health Benefits Grid
Attachment E:	Benefit Tables

Attachment A – Claim inquiry/adjustment request form

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

AETNA BETTER HEALTH® OF WEST VIRGINIA

Claim inquiry/adjustment request form

All information must be completed, or it will be returned without review. Please see the attached Adjustments Guidelines for submission timeframes. **Do not use for an appeal.**

Claim data	
Member Name:	Date of Birth:
Member ID Number:	Claim Number:
Date of Service:	
Provider data	
Provider Name:	
Contact Person:	
Phone Number:	
Mailing Address:	
Fax Number:	
Email Address:	
Request for review with documentation attached	
☐Modifier/Code Review ☐Medical Records (explain below) ☐ER Notes ☐Denied Duplicate in Error ☐Fee Dispute	☐Timely Filing ☐Itemized Bill ☐Corrected/Updated Claim ☐Primary Carrier's EOB ☐Other (explain below)
Description of request	

Send to:
Aetna Better Health of West Virginia
P.O. Box 982965
El Paso, TX 79998-2965

Attachment B – Provider change in information form

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

AETNA BETTER HEALTH® OF WEST VIRGINIA

Provider Change in Information Form

Please complete this form when any of the below takes place within your so we can keep records updated and ensure proper claims payment. Your cooperation and participation are greatly appreciated. Please make copies if you have additional information changes. If you have a change in your Tax ID number, please enclose the new W-9 form.

Notification should be provided as far in advance as possible to the Provider Relations Department prior to the change.

Date these changes became effective:	
Practice Name:	NPI:
Provider Name(s):	NPI:
We are making changes to our: Office Info Billing Info Tax ID	
Current Address:	
Current Phone:	Current Fax:
New Address:	
New Phone:	New Fax:
Current Tax ID Number(s):	New Tax ID Number(s):
Current Billing Address:	
Current Billing Phone:	Current Billing Fax:
New Billing Address:	
New Billing Phone:	New Billing Fax:
Other changes you would like for us to know about:	
Office Manager/Contact:	Phone:
Signature:	Date:

Attachment C – Quick Reference Guide

AETNA BETTER HEALTH® OF WEST VIRGINIA

Quick Reference Guide

Effective: July 1, 2023

Health plan main office	Provider services phone/fax/email
500 Virginia Street, East Suite 400 Charleston, WV 25301	**1-888-348-2922** Fax: **1-866-810-8476** **ABHWV-ProviderRelations@aetna.com**
Hours of operation	Member services phone/fax/email
Monday – Friday 8:30 AM – 5 PM EST Member services is available 24 hours a day, 7 days a week.	**1-888-348-2922** Fax: **1-844-255-7027** **ABH-WV-MemberServices@aetna.com**
Claims/billing address	To file a provider appeal
Aetna Better Health of West Virginia P.O. Box 982965 El Paso, TX 79998-2965	Aetna Better Health of West Virginia PO Box 81040 5801 Postal Rd Cleveland, OH 44181 **Appeals must be received 90 days from original denial*
Case management phone	Complaint and appeals fax
1-888-348-2922	Fax: **1-888-388-1752**
Claims payer ID for EDI	Real time payer ID
128WV	ABHWV
Behavioral health crisis number	Health services prior authorization phone/fax
1-888-348-2922	**1- 844-835-4930** Fax: **1-866-366-7008**
Vendor phone numbers	
SKYGEN Dental **1-855-844-0623** eviCore **1-888-693-3211** Eviti **1-888-482-8057**	VSP Vision **1-800-877-7195** ModivCare **1-844-549-8353**

Attachment D – Behavioral Health Benefits Grid & Billing Policies

Benefits

- Behavioral Health Rehabilitation
- Psychiatric Residential Treatment Facilities for individuals under age 21
- Behavioral Health Outpatient Services
- Psychological Services
- Hospital Services, Inpatient-Behavioral Health and Substance Abuse Use Disorder Stays
- Inpatient Psychiatric Services
- Intensive Outpatient Programs
- IMD stays for members age 21-64

Billing Policies

Aetna Better Health **is not** responsible for:

- any payments for inpatient behavioral health services that are covered by fee-for-service.
- claims incurred within the inpatient behavioral health or residential treatment setting if a member entered the treatment setting as a fee-for-service member.
- claims incurred within the inpatient behavioral health treatment settings if a member entered the treatment setting as a member of another MCO.
- any claims incurred during inpatient stay at Mildred Mitchell Bateman Hospital and William R. Sharpe Jr. Hospital, if a member is between the ages of 22 and 64,

Aetna Better Health **is** responsible for:

- all claims incurred within the inpatient behavioral health treatment settings covered by managed care.

Attachment E - Benefits Tables
MOUNTAIN HEALTH TRUST

Mountain Health Trust: MCO Covered Services

Benefit packages differ, depending on the member's age and whether the member is covered under Mountain Health Trust or West Virginia Health bridge.

MHT MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Ambulatory Surgical Center Services	Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, as well as private practitioners.	Nursing, technicians, and related services. Use of the facilities where surgical procedures are performed; drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure; diagnostic or therapeutic services or items directly related to the provision of a surgical procedure. Materials for anesthesia.	Physician services; lab & x-ray; prosthetic devices; ambulance; leg, arm, back, and neck braces; artificial limbs and DME are excluded.
Cardiac Rehabilitation	A comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore enrollees with heart disease to active, productive lives. Cardiac rehabilitation can be performed in a specialized, freestanding physician directed clinic or in an outpatient hospital department.	Supervised exercise sessions with continuous electrocardiograph monitoring. The medically necessary frequency and duration of cardiac rehabilitation is determined by the enrollee's level of cardiac risk stratification.	
Chiropractor Services	Services provided by a chiropractor consisting of manual manipulation of the spine.	Manipulation to correct subluxation. Radiological examinations related to the service.	Certain procedures may have service limits.
Clinic Services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by a clinic (that is not part of a hospital) on an outpatient basis.	General clinics, birthing centers, and health department clinics, including vaccinations for children.	
Early and Periodic Screening, Diagnostics and Treatment (EPSDT)	Early and periodic screening, treatment, and diagnostic services to determine psychological or physical conditions in enrollees under age twenty-one (21). Based on a periodicity schedule. Includes services identified during an interperiodic and/or periodic screen if they are determined to be medically necessary.	Health care, treatment, and other measures to correct or ameliorate any medical or psychological conditions discovered during a screening. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve a child's current health condition are also covered in EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems.	Limited to individuals under age twenty-one (21).

MHT MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Family Planning Services & Supplies	Services to aid enrollees of child bearing age to voluntarily control family size or to avoid or delay an initial pregnancy.	All family planning providers, services, and supplies.	Sterilization is not covered for enrollees under age twenty-one (21), for enrollees in institutions, or for those who are mentally incompetent. Hysterectomies and pregnancy terminations are not considered family planning services. Treatment for infertility is not covered.
Gender Affirmation for Gender Dysphoria	Gender Dysphoria is a condition defined in the DSM in which a person experiences clinically significant distress or impairment because there is an incongruence between their biological sex and gender identity. Gender affirmation surgeries are covered for individuals diagnosed with gender dysphoria and meeting certain criteria to align their biological sex with their gender identity.	All treating, rendering, ordering, or referring providers. Male to Female (MTF) and Female to Male (FTM) gender affirmation surgeries when conditions of coverage are met and prior authorization is obtained.	Enrollees must be twenty-one (21) years or older prior to being considered for this procedure. No surgery should be performed while a patient is actively psychotic. Contraindications to surgery include an accompanying psychiatric disorder, severe environmental challenges, failure to remain in a cross-sex role during the trial period, illicit drug use, or a lack of Gender Dysphoria diagnosis.
Handicapped Children's Services/ Children with Special Health Care Needs Services	Specialty services provided to handicapped children and those who may be at risk of handicapping conditions.	Provides linkage and coordination of services to all WV children with special needs and limited direct medical services, equipment, and supplies to those families that meet financial and other program eligibility requirements.	Services are provided to children under twenty-one (21) with the following diagnoses, but not limited to: cystic fibrosis; myelocystomeningocele/ myelodysplasia; congenital heart defects; craniofacial deformities; seizure disorders; and metabolic disorders.
Home Health Care Services	Nursing services, home health aide services, medical supplies suitable for use in the home.	Provided at enrollees' place of residence on orders of a physician.	Residence does not include hospital nursing facility, ICF/MR, or state institution. Certain suppliers have service limits.
Hospice	In-home care provided to a terminally ill individual as an alternative to hospitalization.	Nursing care, physician services, medical social services, short-term inpatient care, durable medical equipment, drugs, biologicals, home health aide, and homemaker.	Must have physician certification that enrollee has a life expectancy of six (6) months or less. Enrollees age twenty-one (21) and over waive right to other Medicaid services related to the treatment of terminal illness.

MHT MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Hospital Services, Inpatient	Hospital services, provided for all enrollees on an inpatient basis under the direction of a physician.	All inpatient services, including bariatric surgery, corneal transplants and long-term acute care (LTAC)	Excludes those adults in institutions for mental diseases (IMDs). Excludes behavioral health inpatient stays with a DRG of 425-433 or 521-523 or MS-DRG 880-887 or 894 897. Unlimited medically necessary days based on diagnosis related groups. Transplant services must be in a facility approved as a transplant center by Medicare and prior authorized by Medicaid.
Hospital Services, Outpatient	Medical services furnished on an outpatient basis by a hospital, regardless of the type of provider ordering the service.	Preventive, diagnostic, therapeutic, all emergency services, or rehabilitative medical services.	Services not generally furnished on an inpatient basis by most hospitals in the state. Only technical component of certain services.
Inpatient Rehabilitation	Services related to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals.	Services that are medical inpatient rehabilitation services for Medicaid eligible individuals, and general medical outpatient services which meet certification requirements of the Office of Facility, Licensure and Certification.	
Laboratory and X-Ray Services. Non-Hospital	Laboratory and x-ray services provided in a facility other than a hospital outpatient department.	All laboratory and x-ray services ordered and provided by or under the direction of a physician. Includes laboratory services related to the treatment of SUD.	Must be ordered by physician. Certain procedures may have service limits.
Nurse Practitioners' Services	Services provided by a nurse midwife, nurse anesthetist, family or pediatric nurse practitioner.	Specific services within specialty.	Certain procedures may have service limits.
Other Services Speech Therapy Physical therapy Occupational Therapy	NA	Treatment or other measures provided by speech, physical or occupational therapists to correct or ameliorate any condition within the scope of their practice.	Hearing aid evaluations, hearing aids, hearing aid supplies, batteries and repairs are limited to enrollees under age twenty-one (21) Certain procedures may have service limits, or require prior authorization. Augmentation communication devices limited to children under twenty-one (21) years of age and require prior approval.
Physician Services	Services of a physician to a enrollee on an inpatient or outpatient basis.	Services are provided within the scope of medical practice of an MD or D.O. Includes medical or surgical services of a dentist, medical services related to the treatment of SUD, and fluoride varnish services. Physician services may be delivered using telehealth.	Certain procedures may have service limits, or require prior authorization. Fluoride varnish services may only be provided to children ages six (6) months to three (3) years.

MHT MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Podiatry Services	Foot care services.	Treatment for acute conditions, i.e. infections, inflammations, ulcers, bursitis, etc. Surgeries for bunions, ingrown toe nails. Reduction of fractures, dislocation, and treatment of sprains. Orthotics.	Treatment of children limited to acute conditions. Routine foot care treatment for flat foot, and subluxations of the foot are not covered.
Private Duty Nursing (PDN)	Nursing services for enrollees who require more individual and continuous care than is available from a visiting nurse or routinely provided by hospitals or skilled nursing facilities.	Twenty-four hour nursing care if medically necessary.	Prior approval may be required. Limited to children under twenty-one (21) years of age.
Prosthetic Devices and Durable Medical Equipment (DME)	Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury.	Medically necessary supplies, orthotics, prosthetics and durable medical equipment.	Certain orthotics, prosthetics, and durable medical equipment require prior approval. Certain procedures have service limits. Medical supplies and DME in nursing facilities and ICF/MRs are covered in the per diem paid to these providers. Customized special equipment considered.
Pulmonary Rehabilitation	Individually tailored multidisciplinary approach to the rehabilitation of enrollees who have pulmonary disease.	One-on-one therapeutic procedures to increase strength or endurance of respiratory muscles and functions.	
Right from the Start Services (RFTS)	Services aimed at early access to prenatal care, lower infant mortality and improved pregnancy outcomes.	RFTS - Care coordination and enhanced prenatal care services. OMCFH RFTS Maternity Care Services Project – may provide coverage for women who have been denied Medicaid and are uninsured for maternity care.	Pregnant women (including adolescent females) through twelve (12) month postpartum period and infants less than one (1) year of age. No prior authorizations are required for RFTS services.
Rural Health Clinic Services: Including Federally Qualified Health Centers	Physician, physician assistant, and nurse practitioner providing primary care in a clinic setting.	Physician, physician assistant, nurse practitioner, nurse midwife services, supplies, and intermittent visiting nurse care in designated shortage areas.	
Tobacco Cessation	Treatment for tobacco use and dependence.	Diagnostic, therapy, counseling services, and quit line services. The children's benefit also includes the provision of anticipatory guidance and risk-reduction counseling with regard to tobacco use during routine well-child visits.	
Transportation, Emergency	Transportation to secure medical care and treatment on a scheduled or emergency basis.	Emergency ambulance and air ambulance.	Emergency transportation provided to the nearest resource. By most economical means determined by patient needs.

MHT MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Vision Services	Services provided by optometrists, ophthalmologists, surgeons providing medical eye care and opticians. Professional services, lenses including frames, and other aids to vision. Vision therapy.	Children (under twenty-one (21) -exam, treatment services, lenses, frames, and needed repairs.	Adults limited to medical treatment only. Prescription sunglasses and designer frames are excluded. For adults, eyeglasses are limited to the first pair after cataract surgery. Contact lenses for adults and children covered for certain diagnosis.

Mountain Health Trust: MCO Covered Dental Services

MHTDENTAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Dental Services (Adult)	Services provided by a dentist, orthodontist, or oral surgeon.	1) Emergency procedures to treat fractures, reduce pain, or eliminate infection and; 2) Diagnostic, preventive, and restorative services.	Adult coverage limited to $1,000 per calendar year. Services classified as cosmetic are not covered.
Dental Services (Children)	Services provided by a dentist, orthodontist or oral surgeon or dental group to children under the age of twenty-one (21).	Emergency and non-emergency: surgical, diagnostic, preventive, and restorative treatment, periodontics, endodontics, orthodontics, prosthodontics, extractions, and complete or partial dentures.	Limited to individuals under age twenty-one (21).

Mountain Health Trust: MCO Covered Behavioral Services *

MHT BEHAVIORAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Behavioral Health Rehabilitation for Individuals Under Age twenty-one (21), Psychiatric Residential Treatment Facility (PRTF)	Behavioral health rehabilitation performed in a children's residential treatment facility.	Diagnosis, evaluation, therapies, and other program services for individuals with mental illness, Individuals with Intellectual Disabilities (IID), and SUD.	Procedure specific limits on frequency and units.
Behavioral Health Outpatient Services	Behavioral health clinics, behavioral health rehabilitation, targeted case management, psychologists, and psychiatrists. (Emergency room services are included in the MCO benefits package.)	Diagnosis, evaluation, therapies, including Medication Assisted Treatment (MAT), and other program services for individuals with mental illness, IDD and SUD.	Procedure specific limits on frequency and units. Only assertive community treatment (ACT) providers certified by BMS or the Bureau of Behavioral Health and Health Facilities may provide ACT services. Excludes children's residential treatment.
Psychological Services	Services provided by a licensed psychologist in the treatment of psychological conditions.	Evaluation and treatment, including individual, family, and group therapies. Psychological services may be delivered using telehealth.	Evaluation and testing procedures may have frequency restrictions.
Hospital Services, Inpatient – Behavioral Health and Substance Use Stays	Inpatient hospital services related to the treatment of mental disorders or SUD.	Inpatient hospital services related to the diagnosis, evaluation, and treatment of behavioral health or SUD.	NA
Inpatient Psychiatric Services for Individuals Under Age twenty-one (21)	Inpatient psychiatric facility services furnished at a psychiatric hospital or a distinct part psychiatric unit of an acute care or general hospital under the direction of a physician for individuals under age twenty-one (21).	Active treatment of psychiatric condition through an individual plan of care including post discharge plans for aftercare. Service is expected to improve the enrollee's condition or prevent regression so the service will no longer be needed.	Certification must be made prior to admission that outpatient behavioral health resources available in the community did not meet the treatment needs of the enrollee. Pre-admission and continued stay prior authorization.
Inpatient Psychiatric Services for Individuals Age twenty-one (21) to sixty-four (64)	Inpatient psychiatric facility services furnished at an Institution for mental diseases (IMD)	Active treatment of psychiatric condition through an individual plan of care including post discharge plans for aftercare. Service is expected to improve the enrollee's condition or prevent regression so the service will no longer be needed.	May cover institutions for mental diseases (IMD) stays for enrollees aged twenty-one to sixty-four (21-64) as "in lieu of services" for up to fifteen (15) days during a calendar month.

MHT BEHAVIORAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Drug Screening	Laboratory service to screen for presence of one (1) or more drugs of use.	Screening ordered by the treating practitioner that is deemed medically necessary and reasonable within commonly accepted standards of practice. Results are intended.to alter patient management decisions. Full scope of benefits detailed in WV Provider Manual, Chapter 529.	Standing orders must be individualized for each enrollee and updated every thirty (30) days; drug screenings in excess of twenty-four (24) per calendar year are subject to prior authorization. All limitations are detailed in WV Medicaid Provider Manual, Chapter 529.2.
Substance Use Disorder (SUD) Services	Targeted case management and physician-supervised medication and counseling services provided to treat to those with a SUD.	Comprehensive SUD state plan and waiver services listed in Article III, Section 10.11	Opioid Treatment Program services included in the SUD waiver will be provided through Medicaid FFS.

* An outpatient follow-up session immediately following the discharge from the facility is a MCO covered benefit.

MOUNTAIN HEALTH PROMISE

Mountain Health Promise: MCO Covered Medical Services

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Ambulatory Surgical Center Services	Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, as well as private practitioners.	Nursing, technicians, and related services. Use of the facilities where surgical procedures are performed; drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure; diagnostic or therapeutic services or items directly related to the provision of a surgical procedure. Materials for anesthesia.	Physician services; lab & x-ray; prosthetic devices; ambulance; leg, arm, back, and neck braces; artificial limbs and DME are excluded.
Cardiac Rehabilitation	A comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore enrollees with heart disease to active, productive lives. Cardiac rehabilitation can be performed in a specialized, freestanding physician directed clinic or in an outpatient hospital department.	Supervised exercise sessions with continuous electrocardiograph monitoring. The medically necessary frequency and duration of cardiac rehabilitation is determined by the enrollee's level of cardiac risk stratification.	
Children's Residential Services	Services provided by Children's Residential Facility	All children's residential providers and services.	NA
Chiropractor Services	Services provided by a chiropractor consisting of manual manipulation of the spine.	Manipulation to correct subluxation. Radiological examinations related to the service.	Certain procedures may have service limits.
Clinic Services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by a clinic (that is not part of a hospital) on an outpatient basis.	General clinics, birthing centers, and health department clinics, including vaccinations for children.	

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Early and Periodic Screening, Diagnoses and Treatment (EPSDT)	Early and periodic screening, treatment, and diagnostic services to determine psychological or physical conditions in enrollees under age twenty-one (21). Based on a periodicity schedule. Includes services identified during an interperiodic and/or periodic screen if they are determined to be medically necessary.	Health care, treatment, and other measures to correct or ameliorate any medical or psychological conditions discovered during a screening. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve a child's current health condition are also covered in EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems.	Limited to individuals under age twenty-one (21).
Emergency Shelter Services	Services provided by an emergency shelter provider.	All emergency shelter providers and services.	NA
Family Planning Services & Supplies	Services to aid enrollees of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy.	All family planning providers, services, and supplies.	Sterilization is not covered for enrollees under age twenty-one (21), for enrollees in institutions, or for those who are mentally incompetent. Hysterectomies and pregnancy terminations are not considered family planning services. Treatment for infertility is not covered.
Gender Affirmation for Gender Dysphoria	Gender Dysphoria is a condition defined in the DSM in which a person experiences clinically significant distress or impairment because there is an incongruence between their biological sex and gender identity. Gender affirmation surgeries are covered for individuals diagnosed with gender dysphoria and meeting certain criteria to align their biological sex with their gender identity.	All treating, rendering, ordering, or referring providers. Male to Female (MTF) and Female to Male (FTM) gender affirmation surgeries when conditions of coverage are met and prior authorization is obtained.	Enrollees must be twenty-one (21) years or older prior to being considered for this procedure. No surgery should be performed while a patient is actively psychotic. Contraindications to surgery include an accompanying psychiatric disorder, severe environmental challenges, failure to remain in a cross-sex role during the trial period, illicit drug use, or a lack of Gender Dysphoria diagnosis.
Handicapped Children's Services/ Children and Youth with Special Health Care Needs Services	Specialty services provided to handicapped children and those who may be at risk of handicapping conditions.	Provides linkage and coordination of services to all WV children with special needs and limited direct medical services, equipment, and supplies to those families that meet financial and other program eligibility requirements.	Services are provided to children under twenty-one (21) with the following diagnoses, but not limited to: cystic fibrosis; myelocystomeningocele/ myelodysplasia; congenital heart defects; craniofacial deformities; seizure disorders; and metabolic disorders.
Home Health Care Services	Nursing services, home health aide services, medical supplies suitable for use in the home.	Provided at the enrollee's place of residence on orders of a physician.	Residence does not include hospital nursing facility, ICF/MR, or state institution. Certain suppliers have service limits.

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Hospice	In-home care provided to a terminally ill individual as an alternative to hospitalization.	Nursing care, physician services, medical social services, short-term inpatient care, durable medical equipment, drugs, biologicals, home health aide, and homemaker.	Must have physician certification that enrollee has a life expectancy of six (6) months or less. Enrollees age twenty-one (21) and over waive right to other Medicaid services related to the treatment of terminal illness.
Hospital Services, Inpatient	Hospital services provided for all enrollees on an inpatient basis under the direction of a physician.	All inpatient services, including bariatric surgery, and, corneal transplants.	Excludes those adults in institutions for mental diseases. Excludes behavioral health inpatient stays with a DRG of 425-433 or 521-523 or MS-DRG 880-887 or 894-897. Unlimited medically necessary days based on diagnosis related groups. Transplant services must be in a facility approved as a transplant center by Medicare and prior authorized by Medicaid.
Hospital Services, Outpatient	Medical services furnished on an outpatient basis by a hospital, regardless of the type of provider ordering the service.	Preventive, diagnostic, therapeutic, all emergency services, or rehabilitative medical services.	Services not generally furnished on an inpatient basis by most hospitals in the state. Only technical component of certain services.
Inpatient Rehabilitation	Services related to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals under the age of twenty-one (21)	Services that are medical inpatient rehabilitation services for Medicaid eligible individuals under twenty-one (21), and general medical outpatient services which meet certification requirements of the Office of Facility, Licensure and Certification.	Limited to individuals under age twenty-one (21).
Laboratory and X-Ray Services. Non-Hospital	Laboratory and x-ray services provided in a facility other than a hospital outpatient department.	All laboratory and x-ray services ordered and provided by or under the direction of a physician. Includes laboratory services related to the treatment of substance abuse.	Must be ordered by physician. Certain procedures may have service limits.
Nurse Practitioners' (NP) Services	Services provided by a nurse midwife, nurse anesthetist, family or pediatric NP.	Specific services within specialty.	Certain procedures may have service limits.
Other Services Speech Therapy Physical therapy Occupational Therapy	NA	Treatment or other measures provided by speech, physical or occupational therapists to correct or ameliorate any condition within the scope of their practice.	Hearing aid evaluations, hearing aids, hearing aid supplies, batteries and repairs are limited to enrollees under age twenty-one (21) Certain procedures may have service limits or require prior authorization. Augmentation communication devices limited to children under twenty-one (21) years of age and require prior approval.

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Physician Services	Services of a physician to an enrollee on an inpatient or outpatient basis.	Services are provided within the scope of medical practice of an MD or D.O. Includes medical or surgical services of a dentist, medical services related to the treatment of substance abuse, and fluoride varnish services. Physician services may be delivered using telehealth.	Certain procedures may have service limits or require prior authorization. Fluoride varnish services may only be provided to children ages six (6) months to three (3) years.
Podiatry Services	Foot care services.	Treatment for acute conditions, i.e. infections, inflammations, ulcers, bursitis, etc. Surgeries for bunions, ingrown toenails. Reduction of fractures, dislocation, and treatment of sprains. Orthotics.	Treatment of children limited to acute conditions. Routine foot care treatment for flat foot, and subluxations of the foot are not covered.
Private Duty Nursing	Nursing services for enrollees who require more individual and continuous care than is available from a visiting nurse or routinely provided by hospitals or skilled nursing facilities.	Twenty-four (24) hour nursing care if medically necessary.	Prior approval may be required. Limited to children under twenty-one (21) years of age.
Prosthetic Devices and Durable Medical Equipment	Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury.	Medically necessary supplies, orthotics, prosthetics and durable medical equipment.	Certain orthotics, prosthetics, and durable medical equipment require prior approval. Certain procedures have service limits. Medical supplies and durable medical equipment in nursing facilities and ICF/MRs are covered in the per diem paid to these providers. Customized special equipment considered.
Pulmonary Rehabilitation	Individually tailored multidisciplinary approach to the rehabilitation of enrollees who have pulmonary disease.	One-on-one therapeutic procedures to increase strength or endurance of respiratory muscles and functions.	
Right from the Start Services	Services aimed at early access to prenatal care, lower infant mortality and improved pregnancy outcomes.	RFTS - Care coordination and enhanced prenatal care services. OMCFH RFTS Maternity Care Services Project – may provide coverage for women who have been denied Medicaid and are uninsured for maternity care.	Pregnant women (including adolescent females) through twelve (12) month postpartum period and infants less than one (1) year of age. No prior authorizations are required for RFTS services.
Rural Health Clinic Services: Including Federally Qualified Health Centers	Physician, physician assistant (PA), and NP providing primary care in a clinic setting.	Physician, PA, NP, nurse midwife services, supplies, and intermittent visiting nurse care in designated shortage areas.	
Tobacco Cessation	Treatment for tobacco use and dependence.	Diagnostic, therapy, counseling services, and quit line services. The children's benefit also includes the provision of anticipatory guidance and risk-reduction counseling with regard to tobacco use during routine well-child visits.	
Transportation, Emergency	Transportation to secure medical care and treatment on a scheduled or emergency basis.	Emergency ambulance and air ambulance.	Emergency transportation provided to the nearest resource. By most economical means determined by patient needs.

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Vision Services	Services provided by optometrists, ophthalmologists, surgeons providing medical eye care and opticians. Professional services, lenses including frames, and other aids to vision. Vision therapy.	Children-exam, lenses, frames, and needed repairs.	Adults limited to medical treatment only. Prescription sunglasses and designer frames are excluded. First pair of eyeglasses after cataract surgery. Contact lenses for adults and children covered for certain diagnosis.

Mountain Health Promise: MCO Covered Dental Services

DENTAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Dental Services (Adult)	Services provided by a dentist, orthodontist, or oral surgeon.	Emergency services.	Adult coverage limited to treatment of fractures of mandible and manilla, biopsy, removal of tumors, and emergency extractions. TMJ surgery and treatment not covered for adults.
Dental Services (Children)	Services provided by a dentist, orthodontist or oral surgeon or dental group to children under the age of twenty-one (21).	Emergency and non-emergency: surgical, diagnostic, preventive, and restorative treatment, periodontics, endodontics, orthodontics, prosthodontics, extractions, and complete or partial dentures.	Limited to individuals under age twenty-one (21).

Mountain Health Promise: MCO Covered Behavioral Services *

BEHAVIORAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Behavioral Health Rehabilitation for Individuals Under Age twenty-one (21), Psychiatric Residential Treatment Facility	Behavioral health rehabilitation performed in a children's residential treatment facility.	Diagnosis, evaluation, therapies, and other program services for individuals with mental illness, IID, and substance abuse.	Procedure specific limits on frequency and units.
Behavioral Health Outpatient Services	Behavioral health clinics, behavioral health rehabilitation, targeted case management, psychologists, and psychiatrists. (Emergency room services are included in the MCO benefits package.)	Diagnosis, evaluation, therapies, including Medication Assisted Treatment, and other program services for individuals with mental illness, IID, and substance abuse.	Procedure specific limits on frequency and units. Only assertive community treatment (ACT) providers certified by DHHR or the Bureau of Behavioral Health and Health Facilities may provide ACT services. Excludes children's residential treatment.
Psychological Services	Services provided by a licensed psychologist in the treatment of psychological conditions.	Evaluation and treatment, including individual, family, and group therapies. Psychological services may be delivered using telehealth.	Evaluation and testing procedures may have frequency restrictions.
Hospital Services, Inpatient – Behavioral Health and Substance Abuse Stays	Inpatient hospital services related to the treatment of mental disorders or substance abuse disorders.	Inpatient hospital services related to the diagnosis, evaluation, and treatment of behavioral health or substance abuse disorders.	NA

BEHAVIORAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Inpatient Psychiatric Services for Individuals Under Age twenty-one (21)	Inpatient psychiatric facility services furnished at a psychiatric hospital or a distinct part psychiatric unit of an acute care or general hospital under the direction of a physician for individuals under age twenty-one (21).	Active treatment of psychiatric condition through an individual plan of care including post discharge plans for aftercare. Service is expected to improve the enrollee's condition or prevent regression so the service will no longer be needed.	Certification must be made prior to admission that outpatient behavioral health resources available in the community did not meet the treatment needs of the enrollee. Pre-admission and continued stay prior authorization.
Drug Screening	Laboratory service to screen for presence of one or more drugs of abuse.	Screening ordered by the treating practitioner that is deemed medically necessary and reasonable within commonly accepted standards of practice. Results are intended.to alter patient management decisions. Full scope of benefits detailed in WV Provider Manual, Chapter 529.	Standing orders must be individualized for each enrollee and updated every thirty (30) calendar days; drug screenings in excess of twenty-four (24) per calendar year are subject to prior authorization. All limitations are detailed in WV Medicaid Provider Manual, Chapter 529.2.
Substance Use Disorder (SUD) Services	Targeted case management and physician-supervised medication and counseling services provided to treat to those with a SUD.	Comprehensive SUD state plan and waiver services listed in Article III, Section 11.10	Opioid Treatment Program services included in the SUD waiver will be provided through Medicaid FFS.
Serious Emotional Disturbance Waiver Services	Provides children with some mental health conditions, special intensive support to help them remain in their homes and communities	To be defined, pending approval by CMS	To be defined, pending approval by CMS.

* An outpatient follow-up session immediately following the discharge from the facility is an MCO covered benefit.

Medicaid Benefits Covered Under Fee-For-Service (FFS) Medicaid

The following services are excluded from MCOs' capitation rates, but will remain covered Medicaid services for persons who are enrolled in MCOs. The State will continue to reimburse the billing provider directly for these services on a FFS basis. The State may consider the use of specialized carve-outs in the future.

Medicaid Benefits Covered Under FFS Medicaid

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Abortion	Pregnancy termination determined to be Medically Necessary by the attending physician in consultation with the patient in light of physical, emotional, psychological, familial, or age factors (or a combination there of) relevant to the well-being of the patient.	Drugs or devices to prevent implantation of the fertilized ovum and for medical procedures necessary for the termination of an ectopic pregnancy.	Written physician certification of medical necessity. All Federal and State laws regarding this benefit must be adhered to.
Early Intervention Services for Children Three (3) Years and Under	Early intervention services provided to children three (3) years and under through the Birth to Three program.	Services provided by enrolled Birth to Three (3) providers.	
Intermediate Care Facility for IID (ICF/IID)	Community based services for IID and those with related conditions.	Services provided both in and out of a group living facility which include but are not limited to: physician services, nursing services, dental, vision, hearing, laboratory, dietary, recreational, social services, psychological services, habilitation, and active treatment	Services are provided based on a plan of care developed by an interdisciplinary team headed by a physician. Enrollee must be certified as needing ICF/IID level of care by physician and psychologist. Limited to the first thirty (30) days.
Nursing Facility Services	Facility based nursing services to those who require twenty-four (24) hour nursing level of care.	Full range of nursing, social services and therapies.	Not covered.
Personal Care Services	Medically necessary activities or tasks ordered by a physician, which are implemented according to a Nursing Plan of Care developed and supervised by a registered nurse. These services enable people to meet their physical needs and be treated by their physicians as outpatients, rather than on an inpatient or institutional basis.	Services include those activities related to personal hygiene, dressing, feeding, nutrition, environmental support functions, and health-related tasks.	Room and board services, services which have not been certified by a physician on a Personal Care Medical Eligibility Assessment (PCMEA) or are not in the approved plan of medically necessary care developed by the registered nurse, hours that exceed the sixty (60) hours PMPM limitation that have not been prior authorized, services provided by an enrollee's spouse or parents of a minor child, and supervision that is considered normal childcare.
Personal Care for Individuals Enrolled in the Aged/Disabled Waiver	Community care program for elderly.	Assistance with activities of daily living in a community living arrangement. Grooming, hygiene, nutrition, non-technical physical assistance, and environmental.	Limited on a per unit per month basis. Physicians order and nursing plan of care is required.

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Prescription Drugs	Simple or compound substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance.	Prescription drugs dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children to age twenty-one (21), and prenatal vitamins.	Not Covered: Drugs for weight gain, cosmetic purposes, hair growth, fertility, less than effective drugs and experimental drugs. Hemophilia blood factors are covered by FFS. Drugs and supplies dispensed by a physician acquired by the physician at no cost are not covered. Hemophilia-related clotting factor drugs and Hepatitis-C virus-related drugs are covered by FFS.
School-based Services	Services provided by a physical therapist, speech therapist, occupational therapist, nursing care agency, or audiologist in a school-based setting.	Services provided in a school-based setting.	Limited to individuals under age twenty-one (21). Refer to the FFS Medicaid provider manuals for an explanation of service limitations.
Organ Transplant Services	Transplantation of organs and tissues	Organ transplant services are covered when considered generally safe, effective, and medically necessary, and when no alternative medical treatment as recognized by the medical community is available. The transplant must be utilized for the management of disease as a recognized standard treatment in the medical community and must not be of an investigational or research nature and must be used for end-stage diseases, not as prophylactic treatment.	Corneal transplant services are covered under managed care, not FFS.
Transportation, Non-emergency	Routine medical transportation to and from Medicaid/WVCHIP covered scheduled medical appointments.	Includes transportation via multi-passenger van services and common carriers such as public railways, buses, cabs, airlines, and private vehicle transportation by individuals. Ambulance services as appropriate	Prior authorization by BMS is required for multi-passenger van services. Prior authorization by county DHHR staff is required for transportation by common carriers. Prior authorization by BMS may be required for non-emergency ambulance transportation.
Opioid Treatment Program services under the Substance Use Disorder (SUD) Services 1115 waiver	Physician-supervised daily or several times weekly opioid agonist medication and counseling services provided to maintain multidimensional stability to those with severe opioid use disorder	Comprehensive opioid MAT program including medication, treatment services and laboratory services.	Must be provided in a BMS-licensed methadone clinic and in accordance with ASAM® criteria.

Abortion Services

Under the terms of this Contract, MCO may not reimburse Medicaid/WVCHIP providers for the services provided to Mountain Health Trust enrollees under any reported and verified abortion CPT codes. Abortion Services will be reimbursed under FFS Medicaid.

Intellectual/Developmental Disabilities (I/DD)and Aged/Disabled Waivers

The following services are excluded from the MCO's capitation rates and will be provided under separate waivers:

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Aged/Disabled Waiver	Community based services for aged/disabled as an alternative to nursing facility care.	Nursing care, transportation, and homemaker services.	May not be provided in a hospital, nursing facility, or ICF/IID. Cost of service must be less than nursing facility care.
I/DD Waiver	Community based services for IID/developmentally disabled individuals as an alternative to ICF/IID level of care.	Day and residential habilitation (aggressive active treatment), respite, transportation, and case management.	May not be provided in a hospital, nursing facility, or ICF/IID. Cost of service must be less than nursing facility care.