AETNA BETTER HEALTH® OF ILLINOIS
Provider Newsletter June 2017, Vol. 7

www.aetnabetterhealth.com/illinois

With questions or concerns, please contact Provider Services at 866-212-2851 “Option 2”

We heard you! Weekend Policy Change

Recently you received a letter detailing changes in our weekend policy. As a reminder, we have included the details of the letter below.

We are writing to inform you of a policy change related to our "Weekend Utilization Management Policy" that was implemented in July 2016. Aetna Better Health of Illinois has heard your feedback and we are adjusting the policy based on your suggestions.

Effective immediately we are making the following changes:

1. Providers will no longer be required to submit utilization management requests on the weekend. These requests that are not considered "urgent concurrent" and detailed supporting clinical information can be submitted on the next business day.
2. We will continue to review urgent concurrent requests received from providers as mandated by NCQA accreditation guidelines. Plans must respond to urgent concurrent requests within 24 hours of receipt. Please note the following:

Though admissions are "urgent concurrent reviews", we cannot approve without complete clinical information. If we receive a face sheet with an ICD 10 diagnosis code, or other limited clinical information, we are required to review. Lack of clinical information will necessitate a denial. UM nurse summaries, ED notes alone, InterQual or Milliman CareWebQI screen shots are insufficient to support an approval. We are unable to approve inpatient level of care with incomplete clinical information.

An Urgent concurrent review is defined by NCQA as:

- "Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request."
  https://www.aetnabetterhealth.com/Illinois/

To improve efficiency of requests received for inpatient level of care we ask the following:

- Please send us the needed and complete clinical information. We are unable to review and approve inpatient level of care without sufficient clinical information. If we receive a face sheet with an ICD 10 diagnosis code, or other limited clinical information, we are required to complete a review. Lack of clinical information will necessitate a denial being issued and will delay timely and accurate review requests. UM nurse summaries, ED notes alone, InterQual or Milliman CareWebQI screen shots are not clinical information that we are able to make a level of care determination from. We will not be able to approve inpatient level of care with partial clinical information.
- Use observation stays (up to 72 hours for Medicaid and 48 hours for Medicare). If our member is initially treated at an observation level of care, we do not need to review this level of care.
- If the member's care cannot be delivered at an observation level of care, then a request for an inpatient level of care can be made after the member has not responded to treatment at observation level of care or requires a higher level of care based on medical necessity.

Working together we can simplify and improve our utilization review process to meet the care needs of the members and patients we both serve. As always, we appreciate the ability to partner with your organization to provide the best possible to care to Aetna Better Health of Illinois members.

Latest Provider Handbook

We update the provider handbook every year – the latest version is available online at **https://www.aetnabetterhealth.com/Illinois/**.

Working together to improve care transitions

The Aetna Better Health Care Management team is committed to supporting our members and providers during the critical transition of care period. In order to accomplish this, we have assembled a skilled team of clinicians focused on ensuring seamless Care Transitions. Since discharge planning is dynamic and begins at admission, our care transitions team can offer support right from the beginning of an inpatient stay, and remain connected with hospital discharge planners in case things change.

Some of the things we can help with include identifying post-acute care like home health and nursing facilities, assistance with ordering medical supplies and DME, and troubleshooting other complex discharge needs.

After discharge we outreach our members to help reinforce the discharge plan and assess for ongoing care management. We also assist them with scheduling follow up appointments. Working together we can ensure safe discharges and prevent avoidable readmissions! Need discharge planning support? Feel free to email our secure mailbox: ILDischargePlanning@AETNA.com. This mailbox is monitored M-F, 8-5 by live staff who will respond within 24 hours.

For Managed Long Term Services and Supports (MLTSS) Member Rights and Responsibilities – What you should know

Aetna Better Health is committed to treating enrollees with respect and dignity at all times. Members have the following rights and responsibilities.

1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
2. A right to be treated with respect and recognition of their dignity and their right to privacy.
3. A right to participate with practitioners in making decisions about their health care.
4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
5. A right to voice complaints or appeals about the organization or the care it provides.
6. A right to make recommendations regarding the organization's member rights and responsibilities policy.
7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

The provider handbook is located on our website at www.aetnabetterhealth.com/Illinois. It contains information about member rights and responsibilities and is distributed to new providers when they join the network and existing practitioners annually. Aetna Better Health will update the Provider Handbook at least annually and will distribute bulletins as needed to incorporate any changes. Please check our website at www.aetnabetterhealth.com/Illinois for the most recent version of the Provider Handbook and/or updates. The Aetna Better Health Provider Handbook is available in hard copy form or electronic at no charge by contacting our Provider Services department at 1-855-849-3201.

Clinical Criteria for UM Decisions
Aetna Better Health's UM Department uses criteria or guidelines to make decisions based on medical necessity. These guidelines are developed through technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies. The guidelines come from a variety of sources to include:

- Center for Medicare and Medicaid Services (CMS)
- National Coverage Determinations
- Local Coverage Determinations
- CMS Benefit Interpretation Manuals
- Milliman Care Guidelines®
- Apollo Medical Review Criteria
- National Guideline Clearinghouse
- Evidence in the peer-reviewed published medical literature
- Aetna Clinical Policy Bulletins (CPBs)
- Level of Care Utilization System (LOCUS) and Child & Adolescent Level of Care Utilization System (CALOCUS) Guidelines
- American Society of Addiction Medicine (ASAM)

Availability of Criteria
Providers and members have the right to request a copy of a guideline that Aetna Better Health has used to make a treatment authorization decision. Specific criteria or guidelines are available upon request with the following disclosure: "The material provided to you are guidelines used by this plan to authorize, modify, or deny care for the person with similar illnesses or conditions. Care and treatment may vary depending on individual need and the benefits covered under your contract." Criteria are available by request at our office, or you may request that a copy be mailed to you by calling Member Services at 1-855-849-3201.

Clinical Practice Guidelines

Clinical practice guidelines summarize evidence-based management and treatment options for specific diseases or conditions. These guidelines are reviewed nationally and adopted locally by Quality Management/Utilization Management (QMUM) Committee that includes practicing physicians who participate in the plan. This group also suggests topics for guideline adoption, based on relevance to enrolled membership, with high-volume, high-risk, problem-prone conditions as the first priority.

Aetna Better Health recently reviewed and adopted evidence based clinical guidelines which include medical treatment of preventive, acute or chronic conditions, and behavioral health conditions that include but are not limited to:

- National Asthma Education and Prevention (NAEPP) Guidelines for the Diagnosis and Management of Asthma Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma
- U.S. Preventive Services Task Force (USPSTF): Final Recommendation Statement Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening
- American Psychiatric Association (APA): Practice Guideline for the Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder
- Agency for Healthcare Research and Quality (AHRQ): Routine prenatal care
- American Academy of Pediatrics (AAP): Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of ADHD in Children and Adolescents
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Handbook for Providers of Healthy Kid Services
- American Academy of Family Physicians (AAFP): Summary of Recommendations for Clinical Preventive Services

To obtain a full version of the adopted clinical practice guidelines, visit the "For Providers" page on our website at www.aetnabetterhealth.com/illinois or contact your provider relations representative for the Integrated Care Program and Family Health Plan at 1-866-212-2851, Medicare Medicaid Alignment Initiative at 1-866-600-2139, and Managed Long Term Supports and Services at 1-855-849-3201.

Oral Health Progam- Bright Smiles from Birth

Bright Smiles from Birth (BSFB) is a statewide educational program focused on improving the oral health of infants and young children in Illinois. The program is designed to train primary care providers and their staff on how to integrate oral health into well-child visits, as recommended by Bright Futures and the American Academy of Pediatrics. The program also guides participants on appropriate intervention strategies once high-risk patients are identified, including patient education, referral to dental homes, and application of fluoride varnish.

There is no cost for the program and providers throughout the state who complete the BSFB training are eligible for reimbursement through Medicaid for fluoride varnish application.

After completing the training program, participants will be able to:

- Describe the pathogenesis of early childhood caries (ECC)
- Determine risk factors associated with ECC
- Conduct an oral health screening and apply fluoride varnish
- Provide anticipatory guidance to families
- State the importance of primary care provider's role in oral health
- Referral to a Dental Home when appropriate

ICP, MMAI and FHP Programs- Case Management

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

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

To make referrals for case management consideration, please call Member Services at 1-866-600-2139 (MMAI) 1-866-212-2851 (ICP and FHP). A case manager will review and respond to your request within 3-5 business days.

Disease management

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

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

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

DM Programs available to members include:

- Asthma
- Diabetes
- Depression
- Congestive Heart Failure (CHF)/Coronary Artery Disease (CAD)
- Chronic Obstructive Pulmonary Disease (COPD)

For our pediatric Medicaid members, we developed disease management programs for children with asthma and diabetes. Also, all of our DM programs address co-occurring, physical concerns like obesity and hypertension and behavioral health conditions like depression and anxiety. If you have a member who has one of the above listed chronic conditions, you or your staff can make a referral to our Disease Management Program at any time. To make a referral, please call Member Services at 1-866-600-2139 (MMAI) 1-866-212-2851 (ICP and FHP) and ask for Disease Management.

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Access to UM Staff

Aetna Better Health of Illinois' Utilization Management staff is available 7 am to 7 pm CST Monday through Friday via the toll free number 1-866-600-2139 (MMAI) or 1-866-212-2851 (ICP and FHP).

Clinical information for non-urgent UM requests can be faxed to 1-855-320-8445.

For urgent medical requests, please call our toll free number 1-866-600-2139 (MMAI) or 1-866-212-2851 (ICP and FHP) (after the "Provider" prompt, select option 2 and then select option 4) and fax clinical information through our confidential fax line, 1-855 -687- 6955 that is available 7 days a week. For urgent behavioral health requests, please call our urgent behavioral health line at 1- 855-795-2802 that is available 7 days a week. Urgent behavioral health requests can also be faxed to 1-855 -687- 6955.

After normal business hours, callers will hear a recorded message with instructions on how they can reach somebody immediately, or will have the option to leave a message which will be responded to the next business day. If the message is urgent, we will respond the next day. If the message is received after midnight on Monday-Friday, the message will be responded to on the same business day. For urgent behavioral health or medical requests after normal business hours, please call our urgent phone line (respective numbers listed above). Clinical information for urgent after hours request can be sent through our confidential fax line, 1-855 687 6955 that is available 7 days a week.

UM staff will identify themselves by name, title and organization name when initiating or returning calls and are available to assist you with questions you may have about Aetna Better Health of Illinois' Utilization Management process.

Affirmative Statements about Incentives

UM decisions are based on appropriateness of care and service and existence of coverage. Aetna Better Health does not specifically reward practitioners or individuals for issuing denials of coverage or care. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization. Providers and practitioners are not prohibited from acting on behalf of the member. Physicians cannot be penalized in any manner for requesting or authorizing appropriate medical care. Practitioners are ensured independence and impartiality in making referral decisions that will not influence:

- Hiring
- Compensation
- Termination
- Promotion
- Any other similar matters

Your Guide to Pharmacy Prior Authorization

Our website provides prescribers with resources and tools to educate you on the process and answer questions that you may have. These resource tools can be found on our website, www.aetnabetterhealth.com/Illinois. Click on the Provider tab to access information that will assist you in prescribing formulary and non-formulary medication. You can access links to obtain forms and valuable information for the Integrated Care Plan (ICP), Premier Plan (Medicare-Medicaid Plan) and Family Health Plan (FHP). Information on our website also includes:

- A list of preferred medications, including any restrictions and/or preferences;
- A list of medications which require prior authorization, and applicable coverage criteria
- A list of drugs which require step-therapy, including drugs which must be tried and failed.
- A list and explanation of drugs which have limits or quotas.
- Procedures for step-therapy, prior authorization, preferred-brand interchange, and therapeutic interchange;
- A process for requesting a drug coverage exception.

How to Use Pharmaceutical Management Procedures

Visit our website at www.aetnabetterhealth.com/Illinois for information about our pharmaceutical management procedures. Click on the Provider tab and select the Plan tab for ICP, FHP, or MMAI to access pharmaceutical management procedures. You can also access prior authorization forms that you can print and fax to us using the links below.

ICP: www.aetnabetterhealth.com/illinois/providers/icp/pharmacy
FHP: www.aetnabetterhealth.com/illinois/providers/fhp/priorauth
MMAI Premier Plan: www.aetnabetterhealth.com/illinois/providers/premier/partd

Please use the MMAI link and go to the Part D Prescription Drugs tab to retrieve the Prior Authorization Criteria Document, step therapy guidelines and quantity limits.

Formulary Updates

Formularies may change. Please view updates in the following links.

ICP: www.aetnabetterhealth.com/illinois/providers/icp/pharmacy
MMAI Premier Plan: www.aetnabetterhealth.com/illinois/providers/premier/partd
FHP: www.aetnabetterhealth.com/illinois/providers/fhp/pharmacy

Medical Records Review

On an annual basis, Aetna Better Health selects medical records of its members to review for compliance with clinical practice guidelines and the medical record documentation standards listed in the Provider Handbook. Consistent organization and documentation in patient medical records is a necessary component to maintain continuity and effective, quality patient care.

The Quality Management (QM) department will reach out to selected primary care providers (PCP) to review members' records for compliance with the documentation standards and clinical practice guidelines. Written notification of review results will be provided to PCP offices after the medical record review has been completed.

Our request for patient information is permissible under HIPAA. The HIPAA privacy rules permit a provider to disclose protected health information to a health plan for the quality-related health care operations of the health plan, provided that 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.

Please be assured, we make every effort to comply with the HIPAA privacy rules and their requirements for the use and disclosure of member protected health information. We inform our members of their privacy rights. For more information on our privacy policies, please visit https://www.aetnabetterhealth.com/illinois/privacy-policy.

Supplemental HEDIS Data Collection

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures designed by the National Committee for Quality Assurance (NCQA) for the managed care industry. HEDIS is a tool used by more than 90 percent of health plans to measure performance. It can assist you in providing timely and appropriate care for your patients and provide you with a picture of their overall health and wellness.

The HEDIS 2017 project involved collecting nearly 20,000 records from our providers! We will be seeking your support to reduce the amount of records that need to be collected for the HEDIS 2018 project (services provided in CY 2017). We can reduce the number of charts we need to collect and close gaps in care quicker by collecting supplemental HEDIS records throughout the year rather than once during the annual project. This will lessen the administrative burden on your office during HEDIS season and it will allow you to monitor internal performance for key measures throughout the year, rather than once per year.

CPT Category II Codes

CPT category II codes allow you to share specific data quickly and efficiently with Aetna Better Health. When you add CPT category II codes, we don't need to request the medical record from your office during the annual HEDIS project, you can monitor internal performance for key measures throughout the year rather than once per year, and with more accurate data we can better support the care you provide to our members. The table below is a short list of HEDIS measures and their related CPT category II codes.

CPT category II codes are billed in the procedure code field; just as CPT category I codes are billed. The use of a CPT category II code is optional and is not required for correct coding. Because CPT category II codes are used for informational purposes only, they are billed with a $0.00 charge amount. For more information please visit the American Medical Association website at https://www.ama-assn.org/practice-management/category-ii-codes.

HEDIS Measure		CPT Category II code	
Comprehensive Diabetes Care (CDC)	HbA1c	3044F	Most recent HbA1c level less than 7.0%
		3045F	Most recent HbA1c level between 7.0-9.0%
		3046F	Most recent HbA1c level greater than 9.0%
	Nephropathy screening	3060F	Positive microalbuminuria test result documented and reviewed
		3061F	Negative microalbuminuria test result documented and reviewed
	Diabetic Retinal Screening	2022F	Dilated retinal eye exam interpreted by ophthalmologist/optometrist documented/reviewed
		2024F	7 standard filed stereoscopic photos w/interpretation by eye professional documented/reviewed
		2026F	Eye imaging validated to match dx from 7 standard stereoscopic photos results documented/reviewed
Controlling Blood Pressure (CBP) & Comprehensive Diabetes Care (CDC)	Blood Pressure readings	3074F	Most recent systolic blood pressure <130 mm Hg
		3075F	Most recent systolic blood pressure 130-139 mm Hg
		3077F	Most recent systolic blood pressure >=140 mm Hg
		3078F	Most recent diastolic blood pressure <80 mm Hg
		3079F	Most recent diastolic blood pressure 80-89 mm Hg
		3080F	Most recent diastolic blood pressure >=90 mm Hg
Medication Reconciliation Post Discharge (MRP)		1111F	Discharge medications reconciled with the current medication list in outpatient medical record
Care of Older Adults (COA)	Advance Care Planning	1157F	Advance care plan or similar legal document present in medical record
		1158F	Advance care planning discussion documented in medical record
	Medication Review and List	1159F	Medication list documented in medical record
		1160F	Review of all meds by prescriber or clinical pharmacists documented in med record
	Functional Status Assessment	1170F	Functional status assessed
	Pain Screening	1125F	Pain severity quantified, pain present
		1126F	Pain severity quantified, no pain present
		0521F	Plan of care to address pain documented

Aetna Better Health Formularies

You can gain access to the Aetna Better Health of Illinois formularies by visiting our website at http://www.aetnabetterhealth.com/illinois. This can be found under the "For Providers" tab, "Pharmacy " and "Formulary/Preferred Drug List" areas. This will then lead you to access the Aetna Better Health of Illinois Medicaid Preferred Drug List (PDL) and/or the Aetna Better Health of Illinois Medicaid Formulary Search Tool and formulary document.

Please note the formulary can change at any time. This is due to the ever changing world of medicine. If you have any questions in regards to the formulary please feel free to contact us at the toll free at 1-866-212-2851 or visit our website.