Welcome and introductions

Executive
- Terence L. Byrd, Chief Executive Officer
- Linda Steinke, Chief Operating Officer
- Lisa Chandler, Chief Financial Officer
- Dave Hiestand, Chief Medical Officer
- Lashae Higdon, SIU Senior Investigator

Provider Relations/Operations
- John Wheatley, Director, Service Operations
- Vonda Sickles, Manager, Provider Relations
- Cathy LaPointe, Manager, Provider Relations
- Paula Fellows, Manager, Grievances & Appeals

Quality Management
- Donna Hall, Director, Quality Management

Health Services
- Richard Schultz, Vice President of Health Services
- Rhonda Kessler, Director, Clinical Health Services (Case Management)
- Rachel Gresham, Director, Clinical Health Services (Utilization Management)
- Kimberlee Richardson, Director of Behavioral Health
Aetna recently announced changes to plans offered through the Health Insurance Exchange.

Changes *do not* affect Aetna Better Health Medicaid or the coverage our plan provides to nearly 300,000 members in all 120 counties of the Commonwealth.

Aetna coverage through the Health Insurance Exchange is a separate line of business from Aetna Better Health of Kentucky. It was only available in 10 counties, with approximately 800 members enrolled at the time of the announcement.

**Aetna Better Health of Kentucky will continue to serve Kentuckians in 2017.**
Our core values

Integrity
We do the right thing for the right reason.

Excellence
We strive to deliver the highest quality and value possible through simple, easy and relevant solutions.

Inspiration
We inspire each other to explore ideas that can make the world a better place.

Caring
We listen to and respect our customers and each other so we can act with insight, understanding and compassion.

People we serve

Be passionate about the people we serve

Set high expectations, be decisive and execute

Listen to customers, prioritize and deliver value

Trust and respect each other

Be open to all voices and ideas

Communicate with candor

Anticipate the future and make a difference

Coach, mentor and continuously learn

Be courageous, try new things and innovate

Be collaborative, caring and optimistic

Be accountable and honor commitments

Behave ethically and act with integrity

Be collaborative, caring and optimistic
Our members – the center of what we do

- Quality Management
- Provider Relations & Provider Network
- Appeals & Grievances
- Member Services & Member Advocates
- Medical Management
- Operations & Enrollment
- Collaborative Services
Our members – the center of what we do

Member Services & Member Advocates

Member
Member ID cards

– If the member does not have his/her new ID card, you can obtain enrollment verification at http://aetnabetterhealth-kentucky.aetna.com

• Members can request a new copy of their card anytime by contacting Member Services

• Please Note: A temporary ID card can no longer be faxed to a provider’s office.

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AETNA BETTER HEALTH® OF KENTUCKY

Name: Last Name, First Name Date of Birth 00/00/0000
Member ID/State Medicaid ID# 0000000000 Sex X
Primary Care Provider (PCP) Last Name, First Name
PCP Phone 000-000-0000 Effective Date 00/00/0000

RxBIN: 610591 RxPCN: ADV RXGRP: RX8831
For pharmacist use only: 1-855-319-6290

www.aetnabetterhealth.com/kentucky
THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.

In case of an emergency go to the nearest emergency room or call 911.

IMPORTANT NUMBERS FOR MEMBERS
Member Services 1-855-300-5528 (TTY users 711, TDD users 1-800-627-4702)
Behavioral Health 1-888-604-6106
24 Hour Nurse Line 1-855-620-3924

IMPORTANT NUMBERS FOR PROVIDERS
Eligibility 1-855-300-5528
Authorization 1-888-725-4969
Submit claims to
PO Box 65195, Phoenix, AZ 85082-5195
Payer ID 128KY

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Top Call Reasons

• Eligibility Verification
• ID card requests
• PCP change requests
• Inquiry/Education
• Benefits
Member eligibility

- Aetna Better Health of Kentucky member eligibility can be verified through
  - Provider portal ([http://aetnabetterhealth-kentucky.aetna.com](http://aetnabetterhealth-kentucky.aetna.com)), or
  - Member Services 1-855-300-5528
Member Services

Member Services staff are located in Kentucky and they will:

- Provide information on eligibility and benefits
- Assist providers with non-compliant members and/or discharges
- Assist members with available programs and resources
- Assist member in finding providers
- Assist members in filing grievances or appeals

Member Services can be reached at 1-855-300-5528
Community Outreach

• Aetna Better Health of Kentucky has dedicated Community Outreach staff across the state, who work to be visible and accessible local resources for our members, potential members and community partners
• Community Outreach staff work with Provider Relations staff to be a backup contact source within each region
• Community Outreach staff:
  – Present curriculum on a variety of subjects including personal hygiene (adapted to be age-appropriate in schools), bullying prevention, oral health, nutrition, and others
  – Are Certified Presenters in Chronic Disease management and Nurturing Families training
  – Participate in community events, organizations and meetings that reach members, potential members and community partners
  – Provide education and answers about our member benefits
  – Are a point of contact for member concerns

Community Outreach can be reached at (855) 300-5528
Benefit Co-Pays

• Acute Inpatient Hospital Services $25
  • Including Mental Health and Substance Abuse Services

• Chiropractic Services $3

• Emergency Room, non-emergent use $8

• Prescription Drugs, preferred No Co-Pay
• Prescription Drugs, non-preferred $4
Our members – the center of what we do
Aetna Better Health of Kentucky uses a multi-disciplinary approach to enhance the quality of care for our members. Through work group collaboration, member outreach, focus studies and performance improvement projects, our objectives are to positively impact member advocacy, prevention and wellness and quality of care for medical and behavioral health.
Quality Improvement Program

Quality Management:
- Member advocacy for Quality of Care
- Prevention and Wellness programs
- Performance Improvement Projects
  - Readmission prevention, ED utilization, Diabetes Care, ADHD, Post Partum, Severe Mental Illness, Follow Up Health care visits

HEDIS
- EPSDT, Well Child, Well Woman, Medication compliance
- Monthly post card mailings & reminder calls
- Tracfones and Voxiva
  - Federally funded program to provider members with free cell phones
  - Allows for phone calls to and from the health plan that do not deduct from minutes
  - Phone number are captured in Aetna claims and care management systems
  - Unlimited text messaging for member
  - Delivery of text messaging from the health plan is targeted at member’s health condition or wellness activities
- Value Based Savings program
  - Gap in care reports
Performance Improvement Projects

Existing Health Plan PIPs:

Decreasing Avoidable Hospital Readmissions
• Focus: Decreasing avoidable hospital readmissions by educating members on following their treatment plan and following up with their doctors upon discharge.

Secondary Prevention by Supporting Families of Children with ADHD
• Focus: Offering enhanced and comprehensive services (behavioral therapy) to children with ADHD, as well as to their parents, increases the efficacy of treatment for the affected children.

Diabetes: Increasing Comprehensive Diabetes Testing and Screening
• Focus: Member and provider education of the importance of regular testing and medication compliance.

Improving Postpartum Care
• Focus: Improve member attendance at timely postpartum visits as per the PPC Postpartum
Performance Improvement Projects

Collaborative PIPs with all MCOs in Kentucky:

Measuring the Appropriate Use and Management of Antipsychotics for Children and Adolescents

• **Focus:** Appropriate use and management of antipsychotic medications for children and adolescents. Identify physicians who may be incorrectly prescribing these medications and provide outreach/education.

Severe Mental Illness

• **Focus:** Appropriate use and management of antipsychotic medications for children and adolescents. Identify physicians who may be incorrectly prescribing these medications and provide outreach/education.

Proposals for 2017:

Follow Up after Hospital Discharge for Mental Illness

• **Focus:** to improve member follow up visits after hospitalizations as per the 7 day Follow-Up After Hospitalization for Mental Illness

Prenatal Smoking

• **Focus:** Improve prenatal screening for tobacco use and Increase the prenatal smoking abstinence rate.
What is HEDIS®?

**Healthcare Effectiveness Data and Information Set**

- A set of standardized performance measures designed by the National Committee for Quality Assurance (NCQA) for the managed care industry
- A tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service
- Designed to allow consumers to compare health plan performance to other plans, “apples to apples”, the ability of smaller plans to compare their quality to larger plans
What is HEDIS®?

- Results from HEDIS® data collection serve as measurements for quality improvement processes and preventive care programs.

- Provides a picture of the overall health and wellness of the plan’s membership allowing them to identify gaps in care and develop programs/interventions to help increase compliance and improve health outcomes.

- HEDIS® consists of over 80 measures across 5 domains of care that address important health issues.
Why is HEDIS® Important to Providers?

- Tool for providers to ensure timely and appropriate care for their patients

- Assists providers in identifying and eliminating gaps in care for the patients assigned to their panel roster

- As a provider’s HEDIS® rates increase, there is a potential for earning additional revenue through the Pay for Quality and other value based payment models

- Can be used as a tool to monitor incentive program(s) compliance
How Can You Improve Your HEDIS® Scores?

- Understand HEDIS® Measure Requirements
- Understand Measure Timelines
- Know Gaps in Care Before Patient Arrives
- Code Correctly
- Document Clearly and Completely
How Can You Improve Your HEDIS® Scores?

1. Be sure you are coding correctly for all the services you provide.
2. Use CPT II billing codes to help increase scores for BMI’s, BMI percentiles, labs, etc.
3. Conduct and bill a well visit with a sick visit for a member who has not had his/her annual physical
4. *Expand a basic sports physical*, especially for adolescents, to include *education* and *anticipatory guidance*. Including these components will increase the Adolescent Well Visit and Well child rates.
5. Contact members that are delinquent in needed care and schedule services.
6. Be sure that follow-up instructions are clear and documented in the medical record (ex: for future appointments and what to do)
7. Schedule the next appointment before the patient leaves the office
8. Collaborate with the health plan on programs and interventions
How We Can Help?

• If the member is compliant, but we don’t have the claim yet, fax the medical record *with* a copy of the gaps in care report for that member to 1-855-415-1215.

• Contact the HEDIS department at 1-855-737-0872 for HEDIS education seminars/webinars and provider toolkits.

• Having trouble getting your members into the office to be seen? Contact our Member Outreach Department. We can help.
Value Based Solutions

Shared Savings

P4Q

PCMH
One More Comment on Documentation and Coding

• The Affordable Care Act established a permanent risk adjustment program to minimize the negative effects of adverse selection and help level the playing field between insurance companies.

• The risk adjustment model uses an individual's demographics and diagnoses to determine a risk score, which is a relative measure of how costly an individual is anticipated to be to the plan.
Documentation and Coding – Risk Scoring

• For outpatient encounters/visits, chronic conditions that require or affect patient care treatment or management should be coded. In treating a patient with chronic conditions, the physician keeps in mind the chronic conditions as s/he considers management options for the acute conditions with which the patient presents.

• Conversely, conditions that do not require or affect patient care treatment or management are not reported.
Documentation and Coding – Risk Scoring

“History Of”

- “History Of” means the patient no longer has the condition;
- Frequent documentation errors regarding use of “History Of”:
  - Coding a past condition as active;
  - Coding “history of” when condition is still active;
- Exception: It is appropriate to document/code “history of” when documenting some status conditions (e.g. Amputation);
- Examples

<table>
<thead>
<tr>
<th>Incorrect Documentation</th>
<th>Correct Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>H/O CHF, Meds Lasix</td>
<td>Compensated CHF, stable on Lasix</td>
</tr>
<tr>
<td>H/O angina, meds nitroquick</td>
<td>Angina, stable on nitro</td>
</tr>
<tr>
<td>H/O COPD, meds Advair</td>
<td>COPD controlled w/Avair</td>
</tr>
</tbody>
</table>
Our members – the center of what we do

Provider Relations & Provider Network

Member
# Who is my Provider Relations Representative?

<table>
<thead>
<tr>
<th>REGION</th>
<th>NAME</th>
<th>TELEPHONE</th>
<th>EMAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1</td>
<td>Regina Gullo</td>
<td>1-502-612-9958</td>
<td><a href="mailto:rlgullo@aetna.com">rlgullo@aetna.com</a></td>
</tr>
<tr>
<td>Region 2</td>
<td>Phillip Kemper</td>
<td>1-502-719-8604</td>
<td><a href="mailto:pxkemper@aetna.com">pxkemper@aetna.com</a></td>
</tr>
<tr>
<td>Region 3</td>
<td>Philip Kemper</td>
<td>1-502-719-8604</td>
<td><a href="mailto:pxkemper@aetna.com">pxkemper@aetna.com</a></td>
</tr>
<tr>
<td>Region 3</td>
<td>Jacqulyne Pack</td>
<td>1-606-331-1075</td>
<td><a href="mailto:jmpack@aetna.com">jmpack@aetna.com</a></td>
</tr>
<tr>
<td>Region 4</td>
<td>Brad Jones</td>
<td>1-270-349-0103</td>
<td><a href="mailto:JonesB11@aetna.com">JonesB11@aetna.com</a></td>
</tr>
<tr>
<td>Region 5</td>
<td>Tanura Moss</td>
<td>1-859-381-7404</td>
<td><a href="mailto:MossT2@aetna.com">MossT2@aetna.com</a></td>
</tr>
<tr>
<td>Region 5</td>
<td>Sherry Farris</td>
<td>1-513-218-7725</td>
<td><a href="mailto:sxfarris@aetna.com">sxfarris@aetna.com</a></td>
</tr>
<tr>
<td>Region 6</td>
<td>JoAnn Rose</td>
<td>1-859-669-6217</td>
<td><a href="mailto:jxrose@aetna.com">jxrose@aetna.com</a></td>
</tr>
<tr>
<td>Region 7</td>
<td>Holly Smith</td>
<td>1-815-641-7411</td>
<td><a href="mailto:SmithH3@aetna.com">SmithH3@aetna.com</a></td>
</tr>
<tr>
<td>Region 8</td>
<td>Jacqulyne Pack</td>
<td>1-606-331-1075</td>
<td><a href="mailto:jmpack@aetna.com">jmpack@aetna.com</a></td>
</tr>
<tr>
<td>Region 8</td>
<td>Lori Kelley</td>
<td>1-859-302-6334</td>
<td><a href="mailto:KelleyL2@aetna.com">KelleyL2@aetna.com</a></td>
</tr>
<tr>
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<tr>
<td>Behavioral Health</td>
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<tr>
<td>All Regions</td>
<td>Caleb Pate</td>
<td>1-502-216-1249</td>
<td><a href="mailto:PateC1@aetna.com">PateC1@aetna.com</a></td>
</tr>
</tbody>
</table>
Provider Relations

• Aetna Better Health of Kentucky has dedicated Provider Relations staff
• Provider Relations will:
  • Visit Providers throughout the year
    – Provide education
    – Provide support on Medicaid policies and procedures
    – Provide contract clarification
    – Assist with demographic changes, terminations
    – Initiate Credentialing
    – Monitor compliance Conduct annual Provider Satisfaction Survey
    – Conduct member compliant investigation
    – Maintain the provider directory
    – Be a point of contact for provider concerns

  Provider Relations can be reached at 1-855-454-0061
Claims Inquiry/Claims Research

1-855-300-5528

Claims Inquiry/Claims Research (CICR) Can:

• Assist with claims questions, inquiries and reconsiderations
• Review claims or remittance advice
• Assist providers with prior authorization questions as it relates to how a claim processed, for other questions about what requires authorization, CICR would transfer to the prior authorization department
• View recent updates
• Locate forms
• Find a participating provider or specialist
• Assist with changes to a practice (add locations, provider termination, etc.)
• Direct providers to the web portal to sign up

Claims Inquiry/Claims Research (CICR) Cannot:

• Assist to obtain a secure web portal or member care login ID
• Provide the login ID numbers
Claims Submission

- Aetna Better Health of Kentucky EDI payer ID: 128KY
- Claims mailing address:
  Aetna Better Health of Kentucky
  P O Box 65195
  Phoenix, AZ 85082-5195
Claim Timely Filing

• Timely filing for Aetna Better Health of Kentucky for initial claims submission follows your Coventry Health Care of Kentucky HMO contract
  – 365 days from date of service unless your contract differs
  – For questions regarding your timely filing deadline, please contact Claims Inquiry/Claims Research or Provider Relations
  – Timely filing guidelines related to member retro eligibility may be adjusted. Please contact your provider relations representative
• Providers have 24 months from the date of the first remittance advice to request an adjustment or to submit a corrected claim
Claim Resubmissions & Reconsiderations

• Resubmission claims may be sent electronically
• Label all corrected claims as “Corrected Claim” on the claim form
  – Send all claim lines again, not just the line being corrected
• Send paper claims for reconsideration with attached documentation to:
  Aetna Better Health of Kentucky
  Attn: Claims Resubmission/Reconsideration
  P.O. Box 65195
  Phoenix, AZ 85082-5195
• Please use the Reconsideration Form
  – Found on the provider website http://aetnabetterhealth.com/kentucky
Claim Requirements: Taxonomy, NPI, and Zip+4

• The correct combination of billing provider taxonomy, rendering provider NPI and billing zip+4 registered with the Commonwealth of Kentucky is required on all claims
  • If the combination billed does not match what is registered with the Commonwealth of Kentucky, claims will reject
• Please reference your Kentucky Department of Health and Human Services provider enrollment approval letters to verify the information being billed is what is registered with the Commonwealth
• Please check with your electronic claims vendor to ensure this information is being transmitted appropriately
• Effective March 2017, you will be required to submit attending providers taxonomy and NPI on UB claim forms. This will require providers to have a Kentucky Medicaid ID number.
Remittance Advice

- Remittance advice are available within the provider portal [http://aetnabetterhealth-kentucky.aetna.com](http://aetnabetterhealth-kentucky.aetna.com)
- ERAs will continue through your electronic vendor, if applicable
- Provider remittance advices will also be mailed

- *If you are holding a CoventryCares check, please cash immediately.*
Remittance Advice

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Serv Code</th>
<th>Med Code</th>
<th>PVN</th>
<th>Claim #</th>
<th>Provider ID</th>
<th>Total CPT</th>
<th>Total Allowable</th>
<th>Total Pmt</th>
<th>Total Co-pay</th>
<th>Total Deductible</th>
<th>Total Balance</th>
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<tr>
<td>01/17/2015</td>
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<td>200</td>
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<td>0</td>
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</tr>
</tbody>
</table>

Provider Name: Johnson, John

Benefit Plan: Program Name

Message:
Aetna Better Health of Kentucky offers the following resources for additional information and assistance:

1. For claims, please visit our provider portal available through our website, [http://aetnabetterhealth.kentucky.aetna.com/](http://aetnabetterhealth.kentucky.aetna.com/), or call 1-855-300-5528 (select prompt for Claims Inquiry). Research to verify the status of your claim(s) or for claim(s) questions.

2. For prior authorization or a claim submission, you must contact your provider directly.

3. You may also visit our website, [http://aetnabetterhealth.kentucky.aetna.com/](http://aetnabetterhealth.kentucky.aetna.com/), for more information.

4. To return this claim, please mail it to:
   Aetna Better Health of Kentucky - FINANCE
   4000 E. Cotton Center Blvd.
   Phoenix, AZ 85034

5. To sign up for Electronic Funds Transfer (EFT) payments or Electronic Remittance Advice (ERA’s), please visit our website at [http://aetnabetterhealth.kentucky.aetna.com/](http://aetnabetterhealth.kentucky.aetna.com/), complete the EFT and/or ERA enrollment forms and follow the instructions on the form for submission.

6. EDI Payroll: 12345

7. For provider training for Aetna Better Health of Kentucky, please contact Provider Relations at 1-855-543-0061.
To return this check please mail to:
Aetna Better Health of Kentucky – FINANCE
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

Please mail a refund check for any overpayment or claim processing errors within 60 days to:
Aetna Better Health of Kentucky - FINANCE
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040
Our Website

- Please visit: [http://aetnabetterhealth.com/kentucky](http://aetnabetterhealth.com/kentucky)
- Our provider website contains resources to assist provider interactions with Aetna Better Health of Kentucky:
  - View and download our provider manual, communications and newsletters
  - Searchable provider directory
  - Reconsideration and appeal forms
  - Clinical practice guidelines
  - Member materials
  - Fraud & abuse information and reporting
  - Gateway to our secure provider web portal
  - Information on resubmission and provider appeals
Provider Portal

• Please visit: http://aetnabetterhealth-kentucky.aetna.com
  – Access the provider section of the web page
  – Access the provider portal/secure provider web portal

• All providers must register for the provider web portal
  – Submit web portal e-registration forms online
  – Fax forms to Provider Relations

• Each TIN will have one account, with a primary representative
  – The primary representative can add authorized representatives within their office to their account

• Contact Provider Relations to register and receive a demonstration
Provider Portal

- Providers will be able to
  - Search member eligibility and verify enrollment
  - Search claims status
  - View claim detail, explanation of benefits and remittance advice
  - View provider lists and panel roster
  - Contact the health plan via secure messaging
Electronic Tools

• **Electronic funds transfer (EFT)**
  – Electronic funds transfer (EFT) is our standard payment method for provider reimbursement.

• **Electronic remittance advice (ERA - 835 files)**
  – Please work with your clearinghouse to ensure you can receive ERA & have the correct file paths

• **Enroll in EFT/ERA electronically by visiting our Secure Web Portal**
  http://aetnabetterhealth-kentucky.aetna.com
  – Paper forms can be found on the provider website

*Sign up for EFT/ERA*
*Please contact Provider Relations at*
*1-855-454-0061*
*or refer to the Provider Representative Listing included here, with questions or to check EFT enrollment status.*
Provider Manual

• The provider manual is a resource for policies and procedures for Aetna Better Health of Kentucky
  – Access it online at: http://aetnabetterhealth.com/kentucky
• Please review this manual for additional information about Aetna Better Health of Kentucky and:
  – Contacts
  – Provider rights and responsibilities
  – Credentialing
  – Member eligibility and enrollment
  – Billing and claims
  – Reconsiderations, appeals and grievances
Our members – the center of what we do

Appeals & Grievances

Member
Appeals

• Our provider appeals process is the mechanism which allows the provider the right to have the plan review it’s decisions regarding provider payment or contractual issues.
  – All appeals are initiated in writing and may be mailed or faxed
  – Please utilize the Provider Appeals Form located on our website
  – Documents to support the appeal should be provided, such as a copy of the claim, remittance advice, medical review sheet, medical records, correspondence, etc.
  – Appeals challenging a claim denial or adjudication must be made within 12 months from the date the claim processed
  – Provider Appeals must be filed no later than 12 months after the date of the adverse action
  – Member Appeals must be filed no later than 30 days after the date of the adverse action
• Appeals are reviewed within 30 calendar days
  – Once you receive a notice of resolution, this will conclude your appeal process
Grievances

- A grievance is described as a verbal or written expression that indicates dissatisfaction or dispute with our policies, procedures, claims, denials or any aspect of health plan functions
- Examples: Quality of care, quality of service, provider behavior, office environment, potential fraud and abuse, service quality issues with one of our staff members, appeal decisions
- Grievance process
  - Acknowledged within 5 calendar days
  - Investigated by provider relations, quality management and/or by the State’s Ombudsman
  - May involve office site visits and assessments, training opportunities
  - Egregious grievances may warrant peer review and/or trigger an off-cycle credentialing review
  - Resolution and response to the member or provider within 30 calendar days
State Fair Hearings

- Option available for members who have completed an internal appeal, which was upheld, with service still denied.
- Requests to be submitted within the 45 days following the last denial letter.
- State Fair Hearing requests are directed to Department for Medicaid Services, Division of Program Quality & Outcomes.
- State Fair Hearing cases are typically pre-service issues.
- Members can designate an authorized representative to act on their behalf, including a provider.
- Requires participation by the member and/or the Authorized Representative, either in person or by phone.
Our members – the center of what we do

Medical Management

Member
Aetna Better Health of Kentucky changed guidelines for determination of medical necessity for Behavioral Health on September 1, 2016

- Hearst Corporation’s MCG evidence-based care guidelines 20th Edition
- Provider educational material is available on the provider portal https://www.aetnabetterhealth.com/kentucky/providers/library
- Criteria for Substance Use Disorder determinations remains unchanged
  - ASAM has been in use since January 1, 2015*

*ASAM: American Society of Addiction Medicine
Prior Authorization

• To request a prior authorization utilize the below tools:
  – Utilize Provider Web Portal PA Requirements Search Tool
  – Providers can continue to request an authorization by phone or fax:
    – Medical Prior Authorization
      • Phone: 1-888-725-4969
      • Fax: 1-855-454-5579
    – Behavioral Health Prior Authorization
      • Phone: 1-888-604-6106
      • Fax: 1-855-301-1564
Prior Authorization

• Providers will be able to look-up Prior Authorization information using a new, online tool on Aetna Better Health secure provider web portal
• The Prior Authorization Requirement Search Tool will allow providers to:
  – Search PA requirements by individual or multiple CPT/HCPCS codes simultaneously
  – Review PA requirements by specific procedures or service groups
  – Receive immediate, detailed Yes/No information regarding PA requirements
Clinical Care Management

• Integrated Care Management
  – Intensive, Supportive, Service Coordination and Population Health
    • Adults, pediatric and perinatal
  – Integrated behavioral and physical health. Single care manager manages the member holistically.
  – Motivational interviewing techniques
  – Condition management (supportive or population health)
    • Diabetes, congestive heart failure, coronary artery disease, asthma, COPD and depression

• Specialty Care Management
  – Hepatitis C, Neonatal Abstinence Syndrome (NAS), HROB, NICU, Lock-in, Foster Care and Guardianship
Clinical Care Management

• **Face-to-face care management**
  – Intensively managed members in care management are eligible for a face-to-face visit.

• **Behavioral Health discharge planning**
  – Partner with psychiatric hospitals discharge planners to prepare members for transition back into the community.
  – Provide follow up with the members according to HEDIS guidelines in effort to coordinate member care that may prevent readmissions.

• **Information Health Line (IHL) 24hr nurse line**
  – Medical line available 24 hours to triage member calls with recommendation for the most appropriate level of care services.
  – Referrals to care management
Fraud, Waste & Abuse

- **Special Investigation Unit (SIU)**
  - Monitoring of fraudulent billing practices
  - Verification of services
  - Documentation review

- **Suspected fraud, waste or abuse can be reported by**
  - Phone: 1-855-300-5528
  - Electronically: Fraud, Waste, & Abuse Reporting Form on our website at [http://aetnabetterhealth.com/kentucky](http://aetnabetterhealth.com/kentucky)
Our members – the center of what we do

Collaborative Services

Member
Partners

Aetna Better Health of Kentucky

- CVS/Caremark
- eviCore – Radiology, Pain Management and Cardiology
- Avesis Dental
- Avesis Vision
Welcomes!!

King’s Daughters to our network!
Thank you

**Integrity**
We do the right thing for the right reason.

**Excellence**
We strive to deliver the highest quality and value possible through simple, easy and relevant solutions.

**Inspiration**
We inspire each other to explore ideas that can make the world a better place.

**Caring**
We listen to and respect our customers and each other so we can act with insight, understanding and compassion.

People we serve
I choose Aetna Better Health because...
Their provider network has doctors I can trust.