Frequently asked questions

Hello Oklahoma Providers!

In response to the insightful discussions held during the **Aetna Better Health® of Oklahoma** provider orientations, we have compiled a document containing the top 50 most frequently asked questions raised by providers. This document aims to provide clarity and transparency on various topics to **Aetna Better Health** services, policies and procedures.

We hope that this resource will serve as a helpful guide for you and your team as you navigate your partnership with **Aetna Better Health**.

Thank you for your continued commitment to delivering high-quality care to our members. For additional support, contact the provider relations team at **ABHOKProviderEngagement@Aetna.com**

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Availity/billing

Question: Can provider data be updated on Availity if incorrect?
Answer: No, not currently. Providers must go through OHCA to ensure the correct information comes over to **Aetna Better Health®**.

Question: OHCA's provider portal allows us to search the treatment history for any member based on the CPT Code. We are allowed to see anytime that CPT code was used by any provider. Will this feature be available on Availity? If not, will we still be able to access this information on OHCA's provider portal?
Answer: No, QNXT does not provide the CPT data in a searchable way through Availity.

Question: Ideally, we want to use our own vendors, with Availity in the middle, to send billing to and receive eligibility status and ERAs from all 3 of the SoonerSelect entities. My vendor says you're working to get things ready for them. Do you anticipate a gap of time between us being required to start sending everything to you instead of the OHCA and you being ready to connect with the vendors?
Answer: There should be no gap, however, it depends on when the reciprocal relationship is established. If you are using your own clearinghouse, you need to make sure your clearinghouse has a reciprocal relationship with Office Ally.

Question: If we are using a 3rd party for billing, will we continue to use the 3rd party by allowing the 3rd party to submit our claims? Is it an extra charge to do so?
Answer: 3rd party vendors can be used for billing but make sure clearinghouses have a reciprocal relationship with Office Ally. You will need to confirm charges with the clearinghouse you are using.

Question: Do we need to use Availity for claim submissions?
Answer: Availity is the **Aetna Better Health** provider portal, which provides functionality for the management of members, claims, authorizations and referrals. To submit claims via Availity, proceed to the button labeled "Medicaid Claim Submission – Office Ally". Here you can submit claims through your Office Ally account or through your own clearinghouse, so long as it has a reciprocal relationship with Office Ally. To avoid incurring fees in setting up an Office Ally account, please use the **Aetna Better Health** link.

Question: Are behavioral health case managers (bachelors' level-non licensed) able to bill/submit claims through Availity?
Answer: If they are certified through ODMHSAS CM certification, they will be able to bill for services as usual.

Question: Is eligibility easily provided online? Will TPL be indicated on the eligibility page?
Answer: Providers will be able to check member eligibility via Availity which is the provider portal or through the OHCA portal or by calling member/provider services line at **1-844-365-4385** and follow the prompts.

Question: Will Providers get training on Availity?
Answer: For Availity training opportunities, the "help & training" section displays on all pages in the portal. You can register for upcoming trainings there.

Question: Can providers submit 837's directly to Availity platform for all 3 MCEs?
Answer: Providers will need to submit claims through either their own clearinghouse, or through Office Ally. Availity is our provider portal that will talk to Office Ally.

Question: We use a clearinghouse connected to our EHR for all other business and it's a really big leap for us to have all of the managed care business outside of it. Can the CEs accept claims from our clearinghouse?
Answer: Yes, as long as you confirm you clearinghouse has a reciprocal relationship with Availity.

Question: Will providers have the capability to manually work a claim within Availity?
Answer: Yes, you will do that through your clearinghouse.

Question: Right now the cut-off time for billing is Wednesday at noon for payment the following Wednesday, will this remain the same?
Answer: Check runs on will occur on Mondays, Wednesdays and Fridays. 90% of clean claims received from providers will be paid within 14 days of receipt.

Prior authorizations

Question: SoonerCare back dates authorizations so if we request an authorization on March 1st but they don't approve it until March 5, they back date to March 1, to the day it was submitted. How will this work with **Aetna Better Health®**?
Answer: **Aetna Better Health** will date the PA on the date it was received.

Question: Are we going to be approved for 3-4 sessions a month, then we would request another PA after we complete the 3-4 sessions? How often can we request a PA? Every 60-90 days, etc?
Answer: We will review based on how it is requested. Usually 6 months at a time.

Question: Will BH authorizations go through the same process as medical authorizations?
Answer: Yes, if a PA is required for BH services. **Aetna Better Health** adopts and maintains medical necessity criteria for use in medical necessity determinations regarding members of **Aetna Better Health**, as specified by state contract or required by state and federal regulations and requirements.

Question: Will the initial authorization for PHP be 90 days?
Answer: SOP of reviews is every 1-2 weeks.

Question: What documentation will be required with the PA (Tx plan, CALOCUS, etc.)?
Answer: Clinical data (psycho/social/behavioral history, mental status, current specific maladaptive behaviors and/or skill deficits, co- occurring disorders, and medical condition(s); treatment plan; compliance with treatment and treatment recommendations, include plan to address non -compliance.

Question: How early can we send a concurrent PA before the previous one laps (example: authorization ends on April 12, concurrent PA submitted when)?
Answer: Up to 72 hours before the previous auth end date.

Question: Will the provider site provide authorization requirements based upon procedure codes or will providers be able to search procedures and auth requirements using Availity?
Answer: PAs are issued based on the procedure and **Aetna Better Health®** will follow OHCA guidelines for PAs.

Question: If a member has a current authorization with OHCA those will be honored once coverage is transferred to the respective entities. For instance, if we have a member approved for 26 units Jan. 1, 2024 through July 29, 2024 those will be honored, and we will not have to submit a new authorization to you all within 90 days of April 1, 2024.
Answer: All previous PA's will be transferred to the contracted entities prior to April 1, 2024 as a part of the transition of care. **Aetna Better Health** will be honoring the previously approved PA's by OHCA for 120 days from April 1, 2024.

Question: None of the 3 groups have forms for submission of PA's, or releases or know if we should just keep using OHCA's forms. They do not know when they will be available.
Answer: PA forms can be found for **Aetna Better Health at this link**.

Question: How often do we submit prior authorizations?
Answer: A PA must be submitted based on the need for services and once the PA has or is about to expire for continuation of treatment and/or for new treatment.

Question: Do women need a PCP referral to see an OBGYN doctor or another provider who offers women's health services. Does this include all things under the scope of OBGYN (i.e., birth control, well woman exams, gynecology problems, family planning, etc)?
Answer: No referrals will not be needed; however, a prior authorization may be required depending on services being rendered.

Question: When requesting a PA will we need to have already assigned a provider to the member?
Answer: No, this is not a required criteria for a PA.

Question: When an initial PA is submitted, how long will it take to get approval or denial?
Answer: **Aetna Better Health** will decide standard PA requests within seventy-two (72) hours of receipt of the request or as expeditiously as the member's health requires. If the provider indicates, or **Aetna Better Health** is aware, that adhering to the standard seventy-two (72) hour timeframe could jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, **Aetna Better Health** will make an authorization decision as expeditiously as necessary and, no later than twenty-four (24) hours after receipt of the request for service. All inpatient behavioral health PA requests will be decided within twenty-four (24) hours.

Question: What BH services will need a prior auth?
Answer: On the provider portal, there is a link to Propat, where they can search a code and the system will let them know if an authorization is needed or not.

CCBHC

Question: What is the prior authorization turnaround time for BH services?
Answer: Non-urgent is 72 hours; urgent pre service is 24 hours; inpatient BH is 24 hours.

Question: What is defined as an "agency" on PA grid?
Answer: The grid is something that was developed by OHCA, so they will need to speak to this particular question. However, if you have specific codes, we can look those up for you.

Question: Once **Aetna Better Health®** implements PAs in Availity, will it still be possible to request treatment durations, such as 6 months?
Answer: Yes.

Question: Will CCBHCs need to obtain prior authorization prior to billing CCBHC services?
Answer: **Aetna Better Health** will use the PA# given by OHCA on the current PA file.

Question: How do we submit inpatient prior authorizations?
Answer: These are requested the same way that any other service is requested.
Submitting the request through the 24/7 Secure Provider Web Portal located on the **Aetna Better Health** website at **AetnaBetterHealth.com/Oklahoma**.
Fax the request form to the **Aetna Better Health** specific fax number. Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing. Through our toll-free number at **1-844-365-4385**, or **visit this page**.

Question: What will be the length of the prior authorization for inpatient services? Current length: detox 7 days, residential treatment 30 days, halfway 30 days, PHP 90 days.
Answer: Length of PA inpatient is 1-3 days; residential is 1-2 weeks; PHP is 1-2 weeks.

Question: What PA will be required for inpatient services (detox, residential, halfway and PHP)?
Answer: Inpatient, Residential (all ASAM levels), and PHP require authorization.

Question: Psychosocial BH rehabilitation services are not listed in your provider manual anywhere; however, we were told that all services would remain - can you clarify if this will be an allowable service with **Aetna Better Health** and what (if any) the requirements for eligibility for this service will be?
Answer: We will continue to cover services currently being offered by OHCA. Eligibility will remain the same as defined by ODMHSAS.

Question: In the Provider manual under telehealth services, it states that "telehealth services are provided at no cost to members or providers. Providers must be licensed (or equivalent)" - does this mean that non-licensed candidates for licensure and pre-licensure provider are not permitted to provide telehealth services to **Aetna Better Health** members? This would be more restrictive than what OHCA currently allows and will impact many members across multiple specialties around the state. Could you please clarify?
Answer: Telehealth services are reimbursable to providers currently approved by OHCA. This includes fully licensed professional and those under supervision for licensure.

Question: Under primary care provider referral it states that the PCPs are "expected to refer" for BH services - is this a requirement for all BH services that they must receive a referral in order to receive, or can members self-refer for BH services?
Answer: Members can self refer. A referral is not required.

Question: Are BH services available for members of ALL ages under **Aetna Better Health®**, or only those members 21 and under? Per the provider manual, page 43: behavioral health coverage for members under 21 years of age "in accordance with federal early and periodic screening, diagnostic and treatment requirements, **Aetna Better Health** will provide coverage for all medically necessary behavioral health services for members under 21 years of age. This applies to children diagnosed with autism spectrum disorder and children for whom a licensed physician, surgeon, licensed mental health professional or psychologist determines that behavioral health services are medically necessary. There are no treatment limitations for behavioral health services for members under 21 years of age."
Answer: This is a statement about our EPSDT services and is required contractually.

Question: Are we as master's level mental health providers required to obtain the psychiatric advanced directive as stated on page 29? If so, is this for new members moving forward, or will we need to obtain it at the first session with current members as well who are **Aetna Better Health** members?
Answer: The State of Oklahoma requires that advance directives be incorporated into member's case file within the **Aetna Better Health** care management system and provider's member medical record, as applicable.

Question: Is targeted CM covered?
Answer: Targeted CM is a covered benefit by BH agencies.

PT/OT/ST

Question: Will physical therapy assistants, occupational therapy assistants, and speech therapy assistants continue to bill **Aetna Better Health** the same way they have been billing SoonerCare?
Answer: The billing processes have not changed. The contracted entities (CE) are required to follow the state billing guidelines.

Question: For therapy services- occupational, physical, speech, and feeding therapy (specifically for pediatrics). Will authorizations carry over and if so, how long?
Answer: All previous PA's will be transferred to the contracted entities prior to April 1, 2024 as a part of the transition of care. **Aetna Better Health** will be honoring the previously approved PA's by OHCA for 120 days from April 1, 2024.

Question: Currently each assistant (PT/OT/ST) is contracted with OHCA and bill under their individual NPI. Will that stay the same or will this become like commercial insurance that does not recognize assistants and they have to bill under their supervisor's NPI and we add modifiers to designate that they are assistants and we are billing as such and should receive a lower amount for the service.
Answer: **Aetna Better Health** is not a commercial plan, but a Medicaid plan, therefore, **Aetna Better Health** is required to follow OHCA billing guidelines. Reimbursement is based on the contractual agreement with **Aetna Better Health** and then the OHCA fee schedule.

Question: The 3 groups provider manuals do not specify much if anything about pediatric therapy.
Answer: PT/OT/ST will be covered for all ages and includes the following for those under age 21: OT/PT - Initial eval covered without PA. Treatment requires PA. Speech: Eval and treatment both require PA.
Allowed coverage includes the following:
PT - eval, treatment and consultation in locomotion or mobility skeletal and muscular conditioning, assistive technology, and positioning to maximize member's mobility and skeletal/muscular well-being. PT may include physical therapy assistants, within the limits of the physical therapist's practice.
OT - evaluation, treatment and consultation in leisure management, daily living skills, sensory motor, perceptual motor, mealtime assistance, assistive technology, positioning, and mobility. OT services may include occupational therapy assistants, within the scope of the occupational therapist's practice.
ST - includes evaluation, treatment, and consultation in communication, oral motor activities, and/or feeding activities provided to eligible members. Services are intended to maximize the member's community living skills and may be provided in the community setting in the member's IP.

Question: Will authorizations be required and what details will be required to obtain and maintain those services?
Answer: For PT and OT, authorizations will be required. The initial evaluation will be covered without PA. Treatment requires PA. For ST, evaluation does not require PA; treatment does require PA. A prior authorization request must include the following:
Current, applicable codes which may include:

- Name, date of birth, sex and identification number of the member
- PCP or treating practitioner/provider
- Name, address, phone and fax number and signature, if applicable, of the referring practitioner or provider
- Name, address, phone and fax number of the consulting practitioner or provider
- Reason for the request
- Presentation of supporting objective clinical information, such as clinical notes, comorbidities, complications, progress of treatment, psychosocial situation, home environment, laboratory and imaging studies, and treatment dates, as applicable for the request

Question: Currently, we can give yearly ST, OT, PT evaluations 60 days before they are due. For example, if a member is due for an eval on March 1, 2024 we can test on Jan. 1, 2024. Will this still be an option, or will we have to wait the 365 days to re-test?
Answer: You will not need to wait 365 days. You may submit up to 60 days prior to the due date.