Provider Newsletter

Contents

Go Online to See Our Latest Provider Manual

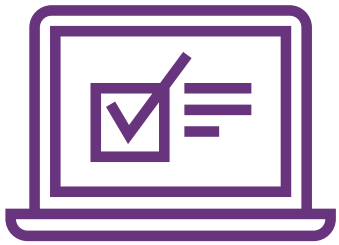
As an Aetna Better Health of Virginia provider, there are certain processes and procedures you need to know and be aware of. Recently, we updated our provider manual based on your feedback and requests. The provider manual contains the answers to most of the questions that you have.

We have updated information about:

- Behavioral health
- Encounters, billing, and claims.
- Prior authorization.
- Grievances and appeals
- Contracting guidelines.

The provider manual is an essential resource for all of our providers. You can print a copy to keep handy, or bookmark the link to the manual on your computer.

To review the latest provider manual, go **here**.



Aetna Better Health® of Virginia

aetna®

VA-21-09-17

aetnabetterhealth.com/virginia

Winter 2021

Important Formulary Information

Visit our Pharmacy page on our website here for important formulary information, such as:

- The Medallion 4.0/FAMIS formulary and search tool.
- The CCC Plus formulary and search tool.
- Formulary updates.

Please review the formulary for any restrictions or recommendations regarding prescription drugs before prescribing a medication to an Aetna Better Health of Virginia patient.

Our Quality Improvement Program

Our Quality Management program is committed to providing high quality services. We focus on improvement in care, member outcomes, and services. We review our Quality Management program annually to assess opportunities for improvement and the need for change for the next year.

This includes an annual assessment of our member population. This is used to drive initiatives and develop interventions pertaining to these four areas of focus:

- Keeping Members Healthy
- Managing Members with Emerging Risk
- Patient Safety and Outcomes Across Settings
- Managing Multiple Chronic Conditions

You can also help us understand where we need to improve our processes. Your satisfaction with us as a health plan is our goal. Some things we do for our members include:

- Reviewing calls and complaints from both members and providers.
- Reviewing all aspects of the health plan through committees that include health plan staff, providers, and members.

...continued

We also work toward providing education regarding prevention and wellness care through telephonic and other outreach for areas including:

- Well visits and dental visit.
- Lead screening.
- Immunizations for children and adolescents.
- Women's health screenings like mammograms and cervical cancer screenings.
- Prenatal and postpartum care.
- Surveying member and provider satisfaction (CAHPS survey, Provider Satisfaction Survey).
- Working with members who have serious health issues through case management.
- Providing members with information on the website about health care costs.
- Measuring provider appointment availability for our members.
- Monitoring phone calls to make sure your call is answered as quickly as possible and that you get correct information.
- Coordination of care.

This list includes just some of our quality programs. Call Provider Relations at **1-800-279-1878** (Medallion 4.0/FAMIS) or **1-855-652-8249** (CCC Plus) to find out more. You can also ask for a written description of our Quality Management Program.

Home-Delivered Meals Are Available to Your Patients

Home-delivered meals are a value-added benefit available to members 21 years of age or older with prior authorization. Members (post-discharge from inpatient stay) can receive two meals per day, which can be tailored to their dietary needs and delivered to their home or community-based setting for up to seven days. Aetna Better Health of Virginia partners with Mom's Meals to provide this value-added benefit to our members.

If you think your patient would be eligible for this benefit, please have them call their case manager at **1-800-279-1878** (Medallion 4.0/FAMIS) or **1-855-652-8249** (CCC Plus).

Interpreter and Translation Services Is a Covered Benefit

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 providers with this, Aetna Better Health makes its telephonic language interpretation service available to providers to facilitate member interactions. These services are free to the member and provider. However, if the provider chooses to use another resource for interpretation services other than those provided by the health plan, the provider is financially responsible for associated costs.

For more information, refer to the "Health Literacy" section in your Aetna Better Health provider manual. To request interpreter and translation services, please call **1-800-279-1878** (Medallion/FAMIS) or **1-855-652-8249** (CCC Plus).

Integrated Care Management Program

Aetna Better Health of Virginia's Integrated Care Management (ICM) program implements a population-based approach to specific chronic diseases or conditions while engaging the member on an individual basis. All Aetna Better Health of Virginia members with identified conditions are auto-enrolled in the chronic condition program based on claims data. The chronic conditions managed include:

- Diabetes.
- COPD.
- Asthma.
- Coronary artery disease.
- Depression.
- Congestive heart failure.

The primary goal of our ICM program is to assist our members and their caregivers to better understand their conditions, update them with new information, and provide them with assistance from our staff to help them manage their disease. Members who do not wish to participate can call member services to disenroll from the program at any time.

Services we offer:

Services for members with chronic conditions include but are not limited to:

- Coordination of care assistance.
- Disease-specific education and support.
- Assistance in receiving community-based services.

In addition to helping members who have special medical needs, we have care management programs for high-risk pregnancies and opioid management, as well as for pregnant women with substance use disorder and their babies.

Members can be referred to the ICM program from a variety of sources, including our medical management programs, discharge planners, members, caregivers, and providers. We encourage you to refer patients who would benefit from chronic condition management.

Need to refer a patient to Care Management?

Please call Member Services at **1-800-279-1878** (Medallion/FAMIS) or **1-855-652-8249** (CCC Plus). We are here to help and look forward to joining you on our members' journey to better health.

Clinical Practice Guidelines

Aetna Better Health of Virginia's Clinical Practice Guidelines and Preventive Services Guidelines are based on nationally recognized recommendations and peer-reviewed medical literature.

The guidelines consider the needs of members, opportunities for improvement identified through our QM Program, and feedback from participating providers.

Guidelines are updated as appropriate, but at least every two years.

Where to learn more:

More information about our practice guidelines, are on our website at **AetnaBetterHealth.com/Virginia**.

Simply scroll down and select Practice Guidelines on the left-hand menu.

Community Resources for Our Members in Need

Aetna Better Health of Virginia's Population Health Management (PMH) program shows that health is more than the just optimal delivery of clinical care.

It's also about the well-being of the total population within communities, including social determinants of health, such as socio-cultural background, economic factors, and the reduction of barriers pertaining to access to food, safety, and other resources.

Our PHM programs allow us to meet members with the right level of services for each person and enable members to use those services to achieve their individual health goals.

You can refer a member by directing them to call our Member Services department at **1-800-279-1878** (Medallion/FAMIS) or **1-855-652-8249** (CCC Plus).

Or, if you would like to offer direct assistance to members in need, feel free to review our list of community resources on our website here.

Diabetes Care

Did you know that health plans monitor quality measures related diabetic care?

There is an extensive list of quality measures around diabetes care, which includes:

- Poorly controlled A1c >9%.
- Adequate controlled A1c <8%.
- Well controlled A1c <7.

As a health plan, we seek to partner with our members and providers to drive to the very best outcomes possible relating to managing diabetes.

Despite A1c quality measures, we recognize A1c targets have morphed over the years. A simple value has changed into a more individualized approach to treatment targets in diabetes.

The American Diabetes Association recommends an A1c goal of less than 7 % for nonpregnant adults.

The goal can be more aggressive, like 6.5%, if the provider and member feel its clinically appropriate, or less stringent, less than 8%, for members where there is a history of severe hypoglycemia, limited life expectancy, advanced microvascular/macrovascular complications, extensive comorbid conditions, or long-standing diabetes where control was difficult to achieve despite glucose monitoring and multiple antidiabetic drugs, including insulin.

A1c monitoring should be conducted every 6 months for members at goal and more frequently (quarterly) for those not at the predetermined A1c target.

Most people with type 2 diabetes should be started on metformin as well as nonpharmacologic strategies like weight management and physical activity.

Early combination therapy can be considered for those who are unlikely to meet their respective goal with monotherapy especially if the member has a compelling indication like:

- Atherosclerotic cardiovascular disease (coronary heart disease, cerebrovascular disease, or peripheral heart disease).
- Heart failure (EF<45%).
- Chronic kidney disease.

Early introduction of insulin should be considered for members with an A1c greater than 10%, ongoing catabolism, or persistent symptoms of hyperglycemia.

The treatment regimen and member adherence should be re-evaluated every 3-6 months. Adjustments should be made based on patient centered glycemic management, and intensification should not be delayed if members are not meeting their goals.

...continued

Some other elements to evaluate in members with diabetes includes:

- Up-to-date vaccinations.
- Smoking cessation.
- Weight management.
- Glucose monitoring at home.
- Blood pressure (ada goal <140/90).
- Lipid management.
- Kidney function.
- Foot care.

It is also recommended that members have a diabetic eye exam once a year, which consists of a dilated retinal exam to examine for diabetes-related damage to blood vessels in the eye.

Providers Can Call Interpreters for Members

Did you know? Providers are able to call interpreters for members who need them. The following interpretation requests are available to both members and providers:

- In-person
  - The interpreter will meet the member at the location (such as the provider office, members home).
  - Requests should be submitted at least three business days ahead of the appointment.
- Over the phone
  - Requests can be submitted same day.
- Video (Zoom)
  - Requests should be submitted at least three business days ahead of the appointment.
  - Emails of each participant are required.

- Scheduled video
  - The interpreter service provides the link, and the member must have a cellphone.
  - Requests should be submitted at least three business days ahead of the appointment.

For more information about having an interpreter available for members, call Provider Services at **1-800-279-1878 (TTY: 711)** for Medallion 4.0/FAMIS or **1-855-652-8249 (TTY: 711)** for CCC Plus.

Better Communication Means Better Patient Care

Treating behavioral health and medical problems together can improve outcomes for both.

How you can help make the connection:

Understand
Understand how important it is to communicate regularly with your patients' medical and behavioral health providers. Your contact helps share clinical information for thorough treatment and continuity of care. It's especially important:

- When patients have coexisting health problems.
- When medications are prescribed.
- If you have medical concerns.

Talk
Talk with your patients about how coordinated care can lead to better results. Ask for their okay for you to communicate with their other treating providers. Working together can mean reduced costs and better results, including:

- Lower mortality.
- Higher satisfaction.
- Lower readmission rates.

Ask your patients to sign a release form
Ask your patients to sign an authorization to release information. Other treating providers need to know diagnoses, treatment plan summaries, medications, referrals, and consultation availability.

Learn more about HIPAA rules for sharing information.

Social Determinants of Health

What are social determinants of health, and how do they affect patients and their health outcomes?

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, and age.

Did you know that you can use ICD-10 codes to document and record SDOH conditions that impact your patients? SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

What are the Z code categories? (Subject to change)

- Z55 – Problems related to education and literacy
- Z56 – Problems related to employment and unemployment
- Z57 – Occupational exposure to risk factors
- Z59 – Problems related to housing and economic circumstances
- Z60 – Problems related to social environment
- Z62 – Problems related to upbringing

...continued

Who can collect SDOH data?

Any member of a person's care team can collect SDOH data during any encounter.

Why collect SDOH data?

- Enhance patient care
- Improve care coordination and referrals
- Support quality measurement
- Data analysis can help improve quality, care coordination, and experience of care

Achieving health equity and putting members on a path to better health our priority. As a participating provider with Aetna Better Health of Virginia, please join us in this journey to health equity and understanding how it connects to SDOH, as well as disparities, culture, bias, and best practices in population-sensitive care.

Behavioral Health Expansion: New Behavioral Health Services for Virginia's Medicaid Members

Aetna Better Health is proud to support the second phase of behavioral health expansion in Virginia, which begins **December 1, 2021**.

The Behavioral Health Redesign for Access, Value, and Outcomes (BRAVO) implements additional services for Medicaid members to improve the behavioral health delivery system in Virginia.

Services that will be offered beginning December 1, 2021 can be found on our website here.

Providers are encouraged to connect members to participating providers for these services as needed. Please contact Member Services for assistance in finding a participating provider or contact the Aetna Better Health Behavioral Health Clinical Liaison in your region.

You may review the Department of Medical Assistance Services behavioral health expansion webpage for more information at **www.dmas.virginia.gov/for-providers/behavioral-health/enhancements**.

If you have any questions, please call **1-800-279-1878 (TTY: 711)** for Medallion 4.0/FAMIS or **1-855-652-8249 (TTY: 711)** for CCC Plus.

Oral Health Screening and Fluoride Varnish

Fluoride varnish is a simple and effective way to help prevent tooth decay in early childhood. Dental fluoride varnish provided by a non-dental medical provider in accordance with the American Academy of Pediatrics guidelines and billed on a HCFA 1500 form is covered.

This program is intended for medical providers, such as pediatricians, family practitioners, and nurse practitioners who treat members up to age three (0-35 months). Fluoride varnish can be applied to teeth up to four times a year.

The procedure code for fluoride varnish application is CPT 99188. The fluoride varnish application is a separate reimbursement. The oral health screen is part of the well-child visit performed by the medical provider.

Additional resources

Virginia Health Catalyst

Find important resources such as:

- Fluoride Varnish Resource Guide
- Fluoride Varnish Billing in Virginia Quick Reference Guide

Bright Smiles for Babies Training (VDOH)

The purpose of the Bright Smiles for Babies (BSB) Fluoride Varnish Program is to reduce the prevalence of early childhood caries (ECC) in infants and toddlers, aged 6 months to 3 years of age.

Children who are at high risk for ECC often experience barriers to accessing timely dental services. The BSB program eases barriers to care by providing preventive services primarily in non-dental settings where parents of young children are seeking other services like doctors' offices and Women, Infants, and Children (WIC) clinics.

Questions about applying fluoride varnish? For more information about how to apply fluoride varnish, providers should contact their local health departments.

New Critical Incident Submission Process

Effective immediately, all providers are required to submit Critical Incident Reports via email to VACriticalIncidents@Aetna.com using the new Critical Incident Form.

The Critical Incident Form can be found on our website at **AetnaBetterHealth.com/Virginia/providers/library**. Select the drop-down under "Provider Forms." Then, select *Critical Incident Form*.

Vital Decisions Living Well Program

Planning Ahead for Future Health Decisions

Our members have access to the Living Well Program offered by Vital Decisions. Vital Decisions can help your patients plan in advance for potential medical decisions, helping members consider what is most important to them based on their health care and quality of life goals.

Their specialists work can work with your patients or a loved one to ensure that their treatment preferences and goals for care are communicated to their family and medical team and reflected in their care plan.

To contact Vital Decisions, call **1-800-301-3984** or visit their website.

Available Soon: New Prior Authorization Form

We are in the process of updating our prior authorization process by standardizing our Prior Authorization Form so that certain aspects of the process can be automated. This will ensure a faster, more efficient prior authorization approval process.

We estimate that this new form will be available sometime this winter. To comply with this new process, providers must begin filling out the new form and removing the old form from service when the new form is available.**The fax number for the prior authorization process will remain the same.**

The new Prior Authorization Form will be available in the same location in our **Document Library**.

Availity: Better for Your Faxing Needs

Did you know? You can submit prior authorizations (PA), medical records, or additional information forms for your requests online through **Availity**.

Register for Availity here.

On Availity, submit a PA or PA inquiry transaction and upload your documentation. Or, view the status to retrieve the event, then upload the documentation. If you did not use Availity for the initial request, you can still use Availity to upload your documentation. Perform a PA inquiry, then follow the status in your Availity PA/referral dashboard to upload your document.

Always include a current form with your initial request. View our forms **here** under "Provider Forms" and complete it online and save it to your computer to use during your PA request. Download a new form each time you need it so you'll always have the most current one.

Availity also offers free live webinars to show you how it works. For help and training, log in to Availity, then select *Help & Training* > *Get Trained* and search for *Authorization Submissions and Follow-Up Training for Aetna Better Health and Mercy Care Providers – Recorded Webinar*.

Cultural Competency Attestation

Culture is a major factor in how people respond to health services. If affects their approach to:

- Coping with illness
- Accessing care
- Taking steps to get well

We ask that all of our providers complete cultural competency training. Patient satisfaction and positive health outcomes are directly related to good communication, in a culturally competent manner, between a member and his or her provider. By completing the attestation form on our website, your records in the Aetna Better Health provider directory will be updated to reflect you have completed this required training.

Learn more about the importance of cultural competency here. Training resources are also available.

As part of our cultural competency program, we also encourage our providers to access information on the Office of Minority Health's web-based A Physician's Guide to Culturally Competent Care. The American Medical Association, American Academy of Family Physicians, and the American College of Physicians endorse this program, which provides up to 9.0 hours of category 1 AMA credits at no cost.

Member Rights and Responsibilities

As a provider to our members, it is important that you know our members rights and responsibilities. To view:

- Medallion and FAMIS
- CCC Plus

Visit **AetnaBetterHealth.com/Virginia/providers/member-rights** on our website.

Thank you for providing our members with the highest quality of care!

Learn More about Our HMO SNP Plan

Interested providers and offices are encouraged to contact Russ Barbour, Director of DSNP, at 804-968-5146.

Aetna Better Health of Virginia (HMO SNP) is a Medicare Special Needs Plan, which means our plan benefits and services are designed for people with special health care needs. Our plan offers additional benefits and services not covered under Medicare, such as dental, hearing aids, and contact lenses.

Aetna Better Health of Virginia (HMO SNP) is available to people who have Medicare and who receive Medicaid assistance from the Commonwealth Coordinated Care Plus (Medicaid).

Additionally, please visit us on the web at **AetnaBetterHealth.com/Virginia-hmosnp**.

Help Stop Fraud!

Fraud, waste, and abuse are widespread in the health care industry and generally result in the increase of health care costs. Aetna Better Health is dedicated to fighting fraud, waste, and abuse through its Fraud Prevention Program. This program is designed to detect and eliminate health care fraud, waste, and abuse.

The most common types of health care fraud, waste, and abuse are:

- Billing for services never provided
- Billing for more expensive services than were actually provided
- Incorrectly stating a diagnosis to get higher payments
- Performing unnecessary services to get higher payments
- Misrepresenting non-covered procedures as medically necessary
- Selling or sharing a member's identification number for the purpose of filing false claims

If you believe you have information relating to health care fraud, waste, and abuse, please contact our Fraud Prevention Department. Our Fraud Prevention Department will review the information and will maintain the highest level of confidentiality as permitted by law.

To report suspected fraud or abuse, contact us:

- Toll-free FWA Hotline is **1-844-317-5825**
- Email **reportfraudabuseVA@aetna.com**

You can help support our mission to reduce and eliminate fraud in the health care industry by following a few simple guidelines:

- Be careful when providing health care information, including a member's identification number.
- Inform your patients to be cautious of "free" medical treatments in which the patient is required to provide them with health care information.
- Aetna Better Health receives bills from providers to pay. This includes doctor visits, inpatient and outpatient services, and equipment and supplies, etc. There will be times when a member receives a letter telling them how we paid for these services. If a member receives a letter, it's important they know to fill it out and return it as soon as possible in the postage paid envelope provided.
- Understand the benefit plan and what types of treatments, drugs, services, etc. are covered.

How to Request Prior Authorization

If a service you are providing our member needs prior authorization, please call:

Program	Phone number	FAX
Medallion/FAMIS	**1-800-279-1878**	**1-877-817-3707**
CCC Plus	**1-855-652-8249**	**1-877-817-3707**

For weekend, after-hours admissions, and urgent/emergent issues after hours, call **1-800-279 1878** (TTY: **711**) for Medallion/FAMIS members and **1-855-652-8249** (TTY: **711**) for CCC Plus members and follow the prompts for afterhours preauthorization. You will be directed to an on-call nurse that can assist you. You may also request a prior authorization on the Provider Portal. When requesting a prior authorization, please include:

- Member's name and date of birth
- Member's identification number
- Demographic information
- Requesting provider contact information
- Clinical notes/explanation of medical necessity
- Other treatments that have been tried
- Diagnosis and procedure codes
- Date(s) of service

Emergency services do not require prior authorization; however, notification is required the same day. For post stabilization services, hospitals may request prior authorization by calling our Prior Authorization department. All out-of-network services must be authorized. Unauthorized services will not be reimbursed and authorizations are not a guarantee of payment.