Pharmacy Change

As you may have heard, the Pharmacy/Prescription Drug Benefits are now managed by the State Medicaid Program. For customer service, please contact Molina at 1-888-483-0801. Effective July 1, 2017, the WV Medicaid Fee for Service program started providing Point of Sale (POS) pharmacy services for all Aetna Better Health of WV members. Prior authorizations obtained under ABH-WV transferred to the Molina system and will be honored for the amount of time through which they were issued by us.

Drug services billed with a CPT or HCPCS code, administered by a healthcare professional, will continue to be reimbursed by the Health Plan. This is the only Pharmacy/Prescription drugs to be billed to the Health Plan. You can bill electronically using our Payor ID of 128WV, or by sending your paper claim(s) to:

Aetna Better Health of WV
P.O. Box 67450
Phoenix, AZ 85082-7450

To obtain a prior authorization after June 30, 2017 for retail pharmacy POS services, please contact the Rational Drug Therapy Program by fax at 800-531-7787 or by phone at 800-847-3859.

Rational Drug Therapy Program WVU School of Pharmacy, PO Box 9511 HSCN, Morgantown, WV 26506; Fax: 1-800-531-7787; Phone: 1-800-847-3859
Telehealth Services

Did you know that Aetna Better Health of WV covers telehealth services? Telehealth services are an interactive audio and video system that permits real-time communication between the member at the originating site and the practitioner at a distant site. This allows the treating practitioner at the distant site to perform a medical examination of the member.

Authorized originating sites include:
- The offices of physicians or practitioners
- Private psychological practices
- Hospitals
- Critical Access Hospitals (CAH)
- Rural Health Clinics (RHC)
- Federally Qualified Health Centers (FQHC)
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)

Authorized distant site practitioners are:
- Physicians
- Family Practice Registered Nurses (APRN)/Nurse Practitioners (NP)
- APRN/Certified Nurse Midwives (CNM)
- Licensed Psychologists (LP)
- Licensed Independent Clinical Social Worker (LICSW)

Telehealth services are valuable in increasing member access to healthcare.

If you would like additional information about telehealth services please see WV BMS Provider Manual, Chapter 519; Policy 519.17. [http://www.dhhr.wv.gov/bms/pages/manuals.aspx](http://www.dhhr.wv.gov/bms/pages/manuals.aspx)

You can also contact our Provider Relations Department at 1-888-348-2922.

Behavioral Health Practitioners and Specialists

Continuity and Coordination of Care

Research indicates that health outcomes are far better when primary care and behavioral health practitioners work in partnership to meet an individuals healthcare needs. In 1996, the Institute of Medicine stated, “Mental health and primary care are inseparable; any attempts to separate the two leads to inferior care.” We expect this collaboration will positively impact the overall health and wellbeing of our members.

Please review the 2017 Behavioral Health and Medical Provider Manuals on our website regarding the Medical Continuity and Coordination of Care to facilitate continuous and appropriate care for our members. We do monitor the coordination and continuity of care across our healthcare network settings and transitions in those settings.

We have identified the continuity and coordination of care for our members is an area we have room for improvement. Therefore, we encourage our behavioral health practitioners and our specialists to always keep the member’s Primary Care Provider (PCP) informed about the member(s) treatment, including hospitalizations, and communicate any assessments or recommended treatment plans to the PCP. All care providers must obtain prior authorization for specified non-emergent inpatient and specified outpatient covered services.
Aetna Better Health of West Virginia

DRUG TESTING POLICY UPDATE

Effective October 1, 2017

Effective **October 1, 2017**, for all places of service except inpatient (Physical Health and Behavioral Health), claims for G0481, G0482, G0483, and G0659 will require medical records that explicitly substantiate the medical necessity of testing for more than 7 drug classes. Further, reimbursement for G0480 will require documentation of a presumptive test **within 5 business days of the date of service**. For questions on this policy change, please contact your Provider Relations Representative with Aetna Better Health of WV.

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**Access to our UM Team**

- **During business hours (8:30 a.m. to 5 p.m.),** you can call **1-888-348-2922** and ask to be connected to a nurse. This number applies to Case or Disease Management nurses.
- **After business hours,** members can call **1-855-5975 or TTY: 711** and they will be connected to the 24-Hour Nurse Line.
- **Members with special communication needs who have access to** TDD telephones may call **711**.
- **Language translation services** are also provided free of charge by calling **1-888-348-2922**.

Practitioners and Providers may call **1-844-835-4930** to request Prior Authorization (or use the Prior Authorization Form at the link provided in the next column), and these requests must include the following:

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

All clinical information should be submitted with the original request.

Please utilize our Prior Authorization Request Form linked here.

[https://www.aetnabetterhealth.com/westvirginia/providers/portal](https://www.aetnabetterhealth.com/westvirginia/providers/portal)
Family planning services

Our members have direct access for family planning services without a referral and may also seek family planning services at the practitioner or provider of their choice (in or out of network). Family planning is covered for all Aetna Better Health of West Virginia members of child-bearing age.

The following services are included:

Family planning services include medical history and physical examinations (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision and continuity of care. These specific services include but are not limited to:

- Comprehensive family planning examination
- Contraceptive medical visits
- Family planning education and counseling by a practitioner
- Prescription contraceptive medications on the Formulary, including LARCs
- Birth control methods ordered at a family planning visit
- Supplies and associated medical and laboratory examinations, including oral and barrier method contraceptives
- Treatment of complications resulting from contraceptive use, including emergency department treatment
- Sterilization, including tubal ligation and vasectomy for members who meet age and consent requirements

*As of 7/1/17 the pharmacy benefit is carved out and handled by the State of West Virginia Fee-For-Service.

Aetna Better Health of West Virginia encourages practitioners to notify the health plan of newly diagnosed pregnancies within seven (7) days.

Aetna Better Health of West Virginia monitors practitioners’ documentation of family planning visits, assessments of sexual activity, and family planning discussions or counseling during medical record reviews.

https://www.aetnabetterhealth.com/westvirginia/providers/portal
2017 Medical Record Review Results

The Quality Improvement Department performs an annual, statewide medical record review to ensure compliance with current standards recognized by agencies that accredit and regulate Aetna Better Health of West Virginia. The purpose of this audit is to evaluate the quality of medical record keeping and to determine if the Plan’s medical record documentation standards are being met.

Member medical records were chosen by random sample. Primary care sites included general practice, internal medicine, family practice, and pediatrics. The medical records were reviewed using the 2017 Medical Record Audit Tool, which includes 19 medical record standards. The performance standard for practitioner offices is an overall score of 85% or greater. In addition to the standards for medical record documentation, all offices are expected to have medical records stored in a secure manner and train staff periodically in member information confidentiality. A total of 85 charts from 17 unique offices were reviewed. Offices who participated in the review will receive a letter with their individual results.

Overall results of the medical record audit showed that the following standards scored below 100%:

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entries in the record contain author signature or initials</td>
<td>94%</td>
</tr>
<tr>
<td>Allergies are noted or NKA if no allergies</td>
<td>95%</td>
</tr>
<tr>
<td>Past Medical History Completed and is easily identified (for members seen three or more times)</td>
<td>87%</td>
</tr>
<tr>
<td>Age Appropriate Immunization record (for members 13 and under)</td>
<td>95%</td>
</tr>
<tr>
<td>Identification of Current Problems</td>
<td>99%</td>
</tr>
</tbody>
</table>

2017 Medical Record Review Results continued on next page.
The 2017 Medical Record Review included an assessment of practitioner documentation of family planning discussions for members ages 15-44 who have been seen 3 or more times. Only 38% of the records reviewed contained this documentation. Since this is a new standard for Aetna Better Health, this question was not included in practitioner office scoring calculations in 2017.

Additional findings for the audited practices were:

- All but one office had a passing score
- The scores for the 17 offices ranged from 83% to 100% with one office scoring 100%
- All offices audited had secure storage of medical records
- All but one office (95%) provided periodic training in medical record confidentiality

A second component of this year's medical record audit was an assessment of the collaboration between behavioral health and medical practitioners, in order to identify opportunities to improve coordination of care between medical and behavioral healthcare. The audit included 17 members who had one or more BH medications prescribed by a psychiatrist. Records were reviewed to determine if the prescribing psychiatrist communicated to the PCP, and to see if the prescribed medications were included on the members’ medication record in the PCP chart. Results of the Behavioral Health Continuity of Care audit are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>% Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing psychiatrist communicated to PCP</td>
<td>4</td>
<td>13</td>
<td>24%</td>
</tr>
<tr>
<td>BH Medications were listed in the member PCP record</td>
<td>20</td>
<td>25</td>
<td>44%</td>
</tr>
</tbody>
</table>

In 2017, an additional component was added to the audit to assess continuity of care between hospital emergency rooms and the member’s PCP. The audit included 16 members who had at least one emergency room visit in 2016. Records were reviewed to see if a discharge summary had been sent to the PCP and if there was evidence in the chart that the PCP viewed either the paper d/c summary or the electronic version. Results of the audit are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>% Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>If member had an ER visit in 2016, is there a discharge summary in the chart</td>
<td>8</td>
<td>8</td>
<td>50%</td>
</tr>
<tr>
<td>Is there evidence in the chart that the PCP viewed either the paper discharge summary or the electronic version.</td>
<td>5</td>
<td>11</td>
<td>31%</td>
</tr>
</tbody>
</table>
Aetna Better Health of West Virginia would like to pass on the following reminders:

- For members age 18 and over, discuss Advanced Directives and document the discussion in the member’s medical record.
- Complete a past medical history for all members.
- A follow-up plan/return visit should be noted for each encounter.
- For members 15-44 years of age, there should be discussion regarding family planning which may include assessments of sexual activity, contraception, STD screening, and/or counseling OR documentation that the member saw a family planning practitioner.
- Communication between behavioral health and medical practitioners is important, especially when behavioral health medications are prescribed.

For a copy of our Medical Record Standards visit the provider section of our website and click on Resources or click on this link: Medical Record Standards for Physicians.

A BIG THANK YOU!

A big Aetna Thank You to all of our provider offices for helping make this a very successful HEDIS season. With your help, we were able to increase our rates in more than 72% of our hybrid HEDIS measures! Many of our rates were among the highest of all Aetna Medicaid plans across the country. That is truly impressive!

We were also able to complete 84% of our chart review without going onsite at your office. This was accomplished via faxing records or giving us remote access. We're hoping this is even higher for our next HEDIS season.

Aetna Better Health providers are the GREATEST!
PAR PROVIDERS MUST REFER TO PAR PROVIDERS

Did you realize that as a PAR provider, you MUST refer our members to other PAR providers? Contractually, if you refer an ABH-WV member to a NON-PAR Provider without a Prior Authorization, you, the PAR provider (even labs or radiology groups), becomes responsible for the NON-PAR Providers billed charges.

If access is an issue, ALWAYS contact our Prior Authorization Department to refer to a NON-PAR Provider.

ALL NON-PAR PROVIDERS ARE REQUIRED TO GET PRIOR AUTHORIZATION TO TREAT OUR MEMBERS!

Prior Authorization Code Changes

<table>
<thead>
<tr>
<th>HCPCs</th>
<th>Description</th>
<th>CPT Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>96116</td>
<td>NUBHVL STATUS XM PR HR W/PT INTERPJ&amp;PREP</td>
<td>MEDICINE—NEUROLOGY AND NEURO</td>
</tr>
<tr>
<td>J7313</td>
<td>INJECTION FA INTRAVITREAL IMPLANT 0.01 MG</td>
<td>HCPCS—DRUGS (NOT ORAL)</td>
</tr>
<tr>
<td>0009M</td>
<td>FETAL ANEUPLOIDY 21 18 SEQ ANALY TRISOM RISK</td>
<td>PATH &amp; LAB—CHEMISTRY</td>
</tr>
<tr>
<td>91110</td>
<td>GI IMAG INTRALUMINAL ESOPHAGUS-ILEUM W/I&amp;R</td>
<td>MEDICINE - GASTROENTEROLOGY</td>
</tr>
<tr>
<td>C1899</td>
<td>LEAD PACEMAKER/CARDIOVERT-DEFIB COMBINATION</td>
<td>HCPCS—C CODES Outpatient PP</td>
</tr>
<tr>
<td>C1896</td>
<td>LEAD CARDIOVRT-DFIB NOT ENDOCARDIAL 1/DUL COIL</td>
<td>HCPCS—C CODES Outpatient PP</td>
</tr>
<tr>
<td>C1895</td>
<td>LEAD CARDIOVERT-DEFIB ENDOCARDIAL DUAL COIL</td>
<td>HCPCS—C CODES Outpatient PP</td>
</tr>
<tr>
<td>C1882</td>
<td>CARDIOVERT-DEFIB OTH THAN SINGLE/DUAL CHAMBER</td>
<td>HCPCS—C CODES Outpatient PP</td>
</tr>
<tr>
<td>C1777</td>
<td>LEAD CARDIOVERT-DEFIB ENDOCARDIAL SINGLE COIL</td>
<td>HCPCS—C CODES Outpatient PP</td>
</tr>
<tr>
<td>C1722</td>
<td>CARDIOVERTER-DEFIBRILLATOR SINGLE CHAMBER</td>
<td>HCPCS—C CODES Outpatient PP</td>
</tr>
<tr>
<td>C1721</td>
<td>CARDIOVERTER-DEFIBRILLATOR DUAL CHAMBER</td>
<td>HCPCS—C CODES Outpatient PP</td>
</tr>
</tbody>
</table>

Appeals

NON-PAR Practitioners DO NOT HAVE APPEAL RIGHTS. NON-PAR Practitioners can dispute, correct, resubmit claims for reconsideration, but they cannot Appeal claims. NON-PAR Practitioners should not send anything related to claims payment issues to the Appeals Department. The only exception are instances where a Non-Par Practitioner or Provider receives a service denial letter from the plan (i.e. inpatient admission level of care). In those instances, we will review an appeal.

Paper Claims

ALL paper claims should be sent to P.O. Box 67450, Phoenix, AZ 85082-7450. NO PAPER CLAIMS SHOULD BE SENT TO THE HEALTH PLAN Charleston, WV, address. Sending paper claims to the Health Plan only delays processing.

https://www.aetnabetterhealth.com/westvirginia/providers/portal
PROVIDER DIRECTORY

We want the Provider Directory on our website to be up to date and to provide accurate practitioner and provider information for our Members. Therefore, please keep in mind when there are changes to a provider(s) or practitioner(s) demographics, to update your Provider Relations Representative or contact your Provider Relations Department via email at:

ABH_WV_ProviderRelations@aetna.com

Always let us know if there is a TIN change. We contract by TIN(s); therefore, if there is a TIN change, there will need to be a new Contract signed to be considered a participating practitioner/provider.

Other information we want to include in our Provider Directory is all locations a practitioner provides services Board Certification information; handicap accessibility information; Ages served; and open or closed PCP panel. If the practitioner wants to close his PCP panel to Medicaid members, he MUST notify all MCOs of his desire to close his PCP panel.

For a PRINTED version of the Provider Directory, please contact your Provider Relations Representative.

See the Web Portal page with our Provider Directory open below.

http://www.aetnabetterhealth.com/westvirginia/providers/portal
Aetna Better Health of WV adopts evidence-based Clinical Practice Guidelines (CPGs) and Preventive Services Guidelines (PSGs) from nationally recognized sources. CPGs are reviews at least every two years or more frequently if national guidelines change within the two-year period.

You can access the CPGs and PSGs on our website. Once on the site, go to Providers then Practice Guidelines. For assistance in obtaining hard copies from the nationally recognized sources, contact your Provider Relations Representative.

### Clinical Practice Guidelines Continued

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis and Management of Asthma</td>
<td>National Heart, Lung and Blood Institute</td>
</tr>
<tr>
<td>Standards of Medical Care in Diabetes</td>
<td>American Diabetes Association</td>
</tr>
<tr>
<td>Diagnosis and Management of Patients With Stable Ischemic Heart Disease</td>
<td>American Heart Association/American College of Cardiology Foundation</td>
</tr>
<tr>
<td>Helping Patients Who Drink Too Much</td>
<td>National Institute on Alcohol Abuse and Alcoholism</td>
</tr>
<tr>
<td>Helping Patients Who Drink Too Much</td>
<td>National Institute on Alcohol Abuse and Alcoholism</td>
</tr>
<tr>
<td>Treatment of Patients With Major Depressive Disorder</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>Diagnosis, Evaluation and Treatment of Attention Deficit Hyperactivity Disorder in Children and Adolescents</td>
<td>American Academy of Pediatrics</td>
</tr>
</tbody>
</table>

### Preventive Guidelines

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grades A &amp; B for Healthy People with Normal Risk</td>
<td>U.S. Preventive Services Task Force</td>
</tr>
</tbody>
</table>

### Disputed Claims—Corrected Claims—Reconsideration Claims

**Disputes (timely filing is within 90 days of Remittance date)**
- Claim payment or denial based on fee schedule or contractual issue
- Claim payment or denial based on a coding issue
- Fill out Resubmission-Dispute Form and submit to your Provider Relations Representative

**Corrected Claims (timely filing is within 90 days of Remittance date)**
- Newly added modifier
- Code changes
- Any change to the original claim
- Mark at top of claim form “CORRECTED CLAIM”
- Fill out Resubmission-Dispute Form and submit to P.O. Box 67450, PHOENIX, AZ 85082-7450 address (NOT THE HEALTH PLAN IN CHARLESTON, WV—they will be shredded and destroyed if sent to the Health Plan)

Continued on Next Page
Reconsiderations (timely filing is within 90 days of Remittance date)

- Claims that denied for more information, i.e. itemized invoice, medical records, coordination of benefits, etc.
- Claims denied as duplicate claim—provide documentation as to why the claim or service was not a duplicate such as medical records showing two services were performed
- Fill out Resubmission-Dispute Form and submit to P.O. Box 67450, PHOENIX, AZ 85082-7450 address (NOT THE HEALTH PLAN IN CHARLESTON, WV—they will be shredded and destroyed if sent to the Health Plan)

Call your Provider Relations Representative for our **Dispute-Resubmission Education** Packet.

Aetna Better Health of West Virginia—Updated Medical and Behavioral Health Provider Manuals can be found on our website at this link:

Medical and Behavioral Health Provider Manuals

Contact your Provider Relations Representative

If you would like a printed version of a Provider Manual

https://www.aetnabetterhealth.com/westvirginia/providers/portal
Our Community Outreach

Staff from Aetna Better Health of West Virginia joined with Mountaineer Food Bank on July 27th to sponsor a mobile food pantry event. The food distribution took place at the Clinton Volunteer Fire Department in Monongalia County. Over 18,000 pounds of produce, bakery, meat and dairy products were distributed. Approximately 225 households took part in the event.
These are the many people who serve you, our practitioners and providers, daily at Aetna Better Health of West Virginia. We represent the many Departments at Aetna Better Health of West Virginia, including Member Services; Medical Management, including your Prior Authorization, Concurrent Review, Case Management and Care Coordinator teams; Quality; Provider Relations; Reporting; Fraud, Waste and Abuse; Finance and Administration.