Provider Newsletter

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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. We are in the process of updating our provider manual based on your feedback and requests. The provider manual contains the answers to most of the questions that you have.

We will have updated information about:

- Important contact information.
- 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.

COVID-19 Billing Reference Guide Updated

We recently updated our *COVID-19 Billing Reference Guide* to reflect new recommendations and billing requirements based on CDC coding guidelines.

To view this updated document, visit our website here and select **Announcements and News**. Then, select **Important Announcements Regarding COVID-19**.

Aetna Better Health® of Virginia

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Winter 2020

DMAS Memo: COVID-19 Flexibility Continuations Until January 20, 2021

DMAS recently released a memo to all participating providers regarding COVID-19 flexibility continuations, which have been extended until **January 20, 2021**.

This memo is an update on certain flexibilities and providers are encouraged to frequently access the DMAS website to check the central COVID-19 response page for FAQs and guidance regarding these flexibilities, as well as ongoing flexibilities for behavioral health and addiction recovery treatment services, here.

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

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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.

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.

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 those 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 get in touch with a care manager?

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 enrollees, opportunities for improvement identified through our QM Program, and feedback from participating practitioners and 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.

Our Population Health Management

Aetna Better Health of Virginia's Population Health Management (PMH) program recognizes 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 meet members with the right level of services for each person and enable members to use those services to achieve their individual health goals.

Cultural Competency Training

Cultural competency is important in providing high-quality care to your patients, our members. We have several training resources for providers regarding cultural competency. The following Aetna Better Health training courses are available upon request for providers:

- Health Equity GMLE Training Inclusion & Equity
- Aetna Medicaid LGBTQ for Providers
- Inclusion & Equity: Seniors
- A Look Through the Lens: Health Equity, Children with Autism, Intellectual & Developmental Disabilities and Special Health Care Needs
- Connecting Culture and Health: The Intersection of Traditional & Modern Medicine

To learn more about cultural competency and the trainings we offer, select here.

Utilization Management (UM)

UM Criteria

To support UM/prior authorization decisions, we use nationally recognized, and/or community developed, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system.

UM/prior authorization staff members that make medical necessity determinations are trained on the criteria and the criteria is established and reviewed according to Aetna Better Health of Virginia policies and procedures. For prior authorization of elective inpatient and outpatient medical services, we use the following medical review criteria.

Criteria sets are reviewed annually for appropriateness to Aetna Better Health of Virginia population needs and updated as applicable when nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate practitioners and providers in developing, adopting, or reviewing criteria.

The criteria are consistently applied, consider the needs of the members, and allow for consultations with requesting practitioners and providers when appropriate.

These are to be consulted in the order listed:

- Criteria required by applicable state or federal regulatory agency
- MCG guidelines
- Aetna Medicaid Pharmacy Guidelines
- Level of Care Utilization System behavioral health services for adults
- American Society of Addiction Medicine substance use services
- Aetna Clinical Policy Bulletins
- Aetna Clinical Policy Council Review

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Medical, behavioral health management criteria and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members.

A free copy of individual guidelines pertaining to a specific case is available for review upon request by calling **1-800-279-1878** (Medallion and FAMIS), or **1-855-652-8249** (CCC Plus).

Need help? Visit our website.

Go to AetnaBetterHealth.com/Virginia and select *For Providers*, then select each section to learn about:

- Member Rights and Responsibilities.
- UM, including how to reach UM staff by phone and after hours, how we make decisions.
- Our affirmative statement about incentives.
- How to obtain UM criteria.
- Clinical Practice and Preventive Guidelines.
- Medical Record Review Standards.
- Our Care Management programs and referrals.
- Available language services and TTY for referrals.

ER Providers and Hospitals: New Process for Referring Members to Appropriate Care Settings

A new process has been created, effective **December 1, 2020**, for hospitals that have elected to refer Medallion 4.0 members only with non-urgent/emergent conditions to alternative settings for treatment.

ER providers can call **1-800-279-1878** (**TTY: 711**) to obtain assistance for members who have non-urgent/emergent conditions, do not need inpatient admission, and are requesting assistance in scheduling an appointment in a different care environment.

If a Medallion 4.0 member comes to the ER and would be served more appropriately elsewhere, and the ER is in the position to assist, call Member Services at the number above. **Identify yourself as calling from an Emergency Department and advise the Member Services agent of the appropriate level of care.** This will help us assist in locating the nearest in-network provider who can offer the right care in the right setting for our member.

For more information on this process, call Member Services. They are available 24 hours a day/7 days a week and can answer any questions you may have.

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.

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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.

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**
HMO-SNP	**1-855-463-0933**	**1-833-280-5224**

You may also request a prior authorization online. Visit aetnabetterhealth.com/virginia. Select For Providers, then 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.

Cultural Competency

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

Patient satisfaction and even positive health outcomes are directly related to good communication between a member and his or her provider.

A culturally competent provider communicates effectively with patients and understands their individual concerns. It's incumbent on providers to make sure patients understand their care regimen. Each segment of our population requires special sensitivities and strategies to embrace cultural differences.

Training resources for our providers
As part of our cultural competency program, we 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**.