Provider Newsletter

Contents

Attention Value Based Solutions Partners!

Be a Part of Our COVID-19 Vaccine Incentive Program

As our Value Based Solutions Partner, Aetna Better Health of Virginia is requesting ***your*** support to increase the number of COVID-19 vaccinated Medicaid members.

Aetna Better Health is implementing a COVID-19 Vaccine Incentive Program. All participating **Value Based Solutions Providers** are eligible and encouraged to participate and can earn financial incentives as part of this program.

The COVID-19 Vaccine Incentive Program will support Medicaid members by:

- Addressing COVID-19 vaccine hesitancy.
- Providing education on the safety and efficacy of the COVID-19 vaccine.
- Conducting outreach to those disproportionately at risk of contracting COVID-19.

Aetna Better Health will incentivize Medicaid members with a $50 Visa gift card per dose of Moderna and Pfizer vaccine and a $100 Visa gift card for the single-dose Johnson & Johnson vaccine.

Interested in learning more about this incentive program? Continue to the next page.

Interested in becoming a Value Based Solutions partner? Call Provider Relations at **1-800-279-1878**.

Aetna Better Health® of Virginia

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How does the program work?

- The program measurement period equals dates of service September 2021 to December 2021.
- Providers will receive a list of attributed members who have not yet received the COVID-19 vaccine.
- Providers are asked to conduct outreach to these attributed members to encourage receipt of the COVID-19 vaccine and provide any needed education on the safety and efficacy of the vaccine.
- Providers will receive $25 for each identified attributed member who receives a complete COVID-19 vaccine during the program measurement period (two dose Pfizer or Moderna or a single dose Johnson & Johnson).
- The COVID-19 vaccine does not have to be administered by the provider or practice.
- If provider does administer the vaccine, provider is advised to use the below codes to submit a claim.
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CPT Code	Description
0001A	COVID-19 Vaccine-Pfizer, 1st Dose, ADM SARSCOV@ 20MCG/.3ML IM
00002A	COVID-19 Vaccine-Pfizer, 2nd Dose, ADM SARSCOV2 20MCG/.3ML IM
0011A	COVID-19 Vaccine-Moderna, 1st Dose, ADM SARSCOV2 100MCG/.5ML IM
0012A	COVID-19 Vaccine-Moderna, 2nd Dose, ADM SARSCOV2 100MCG/.5ML IM
0031A	COVID-19 Vaccine-Admin Fee Janssen (J&J), SARSCOV2 AD26 .5ML IM

When will I be paid?

- Aetna Better Health will review claims data and vaccine registry reports on a quarterly basis and will issue payments accordingly.
- Following the end of each calendar quarter during the program period, Aetna Better Health will review the vaccine registry and claims data and issue payment within standard payment processing terms.
- A check will be mailed to your office to the address on file with Aetna Better Health.

What kind of reports will I receive?

1. A list of attributed members who **have not** received the COVID-19 vaccine or their completed doses
2. A list of attribute members who **have** received the completed dose of the COVID-19 vaccine

For more information about this program, please contact your Network Relations Consultant or Provider Relations **1-800-279-1878**.

Tell Us What You Think!

Our annual *Provider Satisfaction Survey* invitations are being distributed to 1,500 random providers from our network between **July and September 2021**.

Your participation is vital for the improvement of our health plan operations!

- Please ensure your provider demographic information is updated in our system.
  - Call **1-800-279-1878 (TTY: 711)** to update or verify your information.
- Surveys will go out initially via email and will contain a unique survey participation code and instructions.
- Second and third wave surveys will go to non-respondents via physical mail and, eventually, phone outreach.

Reminder: Incorrect Payer ID Notification

Lately, providers have been submitting claims electronically using the incorrect payer ID for Aetna Better Health of Virginia. Providers are submitting these claims using the outdated Coventry payer ID. These claims will no longer be processed on **December 1, 2021**.

Aetna Better Health of Virginia payer ID **128VA** should be used in lieu of Coventry payer ID **25133** for future claims submissions. Provider claims that use Coventry payer ID **25133** will be rejected starting **December 1, 2021**. We are making you aware of this issue now to prevent a delay in claims reimbursement in the future.

For more assistance, contact our Claims department:

- Medallion/FAMIS: **1-800-279-1878**
- CCC Plus: **1-855-652-8249**

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.

Durable Medical Equipment and Supplies Rate Floor Update

Effective **July 1, 2021**, the durable medical equipment (DME) and supplies program has changed as a result of a General Assembly action item, which set a Medicaid rate floor for DME, orthotics, prosthetics, and supplies.

The Department of Medical Assistance Services is requiring Medicaid managed care organizations, including Aetna Better Health, to reimburse at **no less than 90% of the state Medicaid program DME fee schedule for DME, prosthetics, orthotics, and supplies**.

In cases where there is no rate available, we are required to use the reimbursement methodology set forth in *12VAC30-80-30.A(6)* to determine the fee-for-service benchmark rate. For some items or services, because the reimbursement rate is based on the manufacturer's net charge to the provider, an invoice must be submitted with the claim.

This change is not intended to result in a reduction to 90% of the Medicaid program DME fee schedule. It is only to ensure that we do not price DME, complex rehab technology, prosthetics, orthotics, and supplies below the rate floor.

If you have any questions, contact Provider Services at **1-855-652-8249** or via email at **AetnaBetterHealth-VAProviderRelations@Aetna.com**.

Insufficient Documentation Errors

An insufficient documentation error can occur when medical documentation submitted with a claim fails to support payment for the services billed. This happens when it cannot be determined that certain allowed service were:

- Actually provided.
- Provided at the level billed.
- Deemed medically necessary.

Additionally, insufficient documentation errors may occur when a particular part of documentation that is required as a condition of payment is not in the claim.

An example of this might be a provider's signature on an order or a form that needs to be fully completed.

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Some additional examples of insufficient documentation errors may include:

- Progress notes that are incomplete (i.e., no signatures or undated).
- Medical records that have not been authenticated (i.e., no signature or illegible signature).
- No documentation of intent to order services or procedures (i.e., incomplete or no signed order or progress note expressing intent for services to be given).

For more information, please review the Centers for Medicare and Medicaid Services fact sheet on complying with medical documentation requirements.

Pharmacy Prior Authorization (PA): Getting It Right the First Time

Did you know that Aetna Better Health of Virginia maintains pharmacy content monthly? Each month, we make sure resources are accurate and up to date in the Pharmacy section of our provider website. You can access all of that information here.

Our website includes a searchable formulary, printed formulary, PA criteria, and PA forms. Some of the drugs/drug classes have criteria that warrant specific PA forms. It is important that the correct form is chosen to ensure that all the necessary clinicals are supplied.

Our pharmacy call center strives to make the most accurate coverage determination the first time, limiting additional re-work for all, including PA resubmissions, peer-to-peers, and appeals.

Examples of drugs/drug classes that should be submitted on their corresponding PA form:

Topic	Name of PA Form
Atypical antipsychotics for members under 18	Atypical Antipsychotics Less Than 18
Short-acting and long-acting opioids (excluding methadone)	Opioids
Stimulants for members 18 and older	ADD-ADHD Medications Age Limit

All of these forms are available in the Pharmacy section of our website. Click here to review our comprehensive library of PA

Formulary Addition: Suboxone

A change has been made in the Aetna Better Health formulary.

As a result of potential supply chain disruptions related to Suboxone Film, the Department of Medical Assistance Services and Aetna Better Health have added generic Suboxone SL tabs to the common core formulary, effective **August 1, 2021**.

View this formulary addition:

To review the formulary and related utilization management edits, visit our website here.

Does Your Patient Need Help for a Substance Use Disorder?

Drug and alcohol use disorders have reached epidemic levels in the United States. On a national level, the focus is on opioid prescriptions and opioid street drugs.

The global pandemic has exacerbated substance use disorders due to isolation, loneliness, and problems accessing outpatient services and supports.

Statewide use patterns include opioids, alcohol, marijuana, cocaine, and methamphetamine. The number of drug overdoses in Virginia has increased every year since 2017. Substance use disorders occur across all demographics, including age, gender, ethnicity, educational level, and income. Willingness to seek and engage in treatment may be a challenge for many people.

The Addiction Recovery and Treatment Services (ARTS) benefit offers an array of services for persons seeking help for opioid or other substance use disorders.

ARTS benefits cover a wide range of addiction treatment services, which are based on American Society of Addiction Medicine criteria.

ARTS services include the following:

- Inpatient hospitalization
- Residential substance use services
- Partial hospitalization program
- Intensive outpatient program
- Medication assisted treatment for opioid use disorders
- Care management services
- Peer support services

If you want to learn how our Behavioral Health department can provide support, you can call Member Services at **1-800-279-1878**, Monday through Friday, 8 AM to 5 PM.

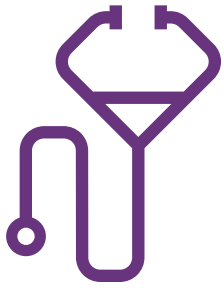
Treatment for Acute Bronchitis

Did you know there is a HEDIS measure for **Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis**?

This quality measure looks to determine when an antibiotic was not prescribed, despite an office visit for acute bronchitis/ bronchiolitis. An estimated 80% to 90% of all antibiotic use occurs in the outpatient setting, and 30% to 50% of those antibiotic prescriptions are estimated to be unnecessary.

The Center of Disease Control and Prevention indicates that most acute bronchitis will resolve regardless of whether it is viral or bacterial in nature. Symptoms will typically last no greater than 3 weeks and may include:

- Cough.
- Chest soreness.
- Fatigue.
- Headache.
- Body aches.
- Sore throat.



Watchful waiting should be considered. Antibiotics will not change the clinical course but may increase the risk of antibiotic resistance.

To learn more, visit the National Committee for Quality Assurance (NCQA) website here.

Reminder: Join Availity, Our New Provider Portal!

This article is to serve as a reminder that Aetna Better Health of Virginia has transitioned to a new Provider Portal, Availity. With Availity, you will be more easily able to support your patients, our members. Some areas of increased functionality include:

- Appeals and grievance submissions.
- Prior authorization submission and status lookup.
- Claims submissions and status inquiry.
- Panel roster lookup.

Additionally, Aetna Better Health will continue implementing new and improved functions throughout the year.

If you are already registered in Availity, you will simply select Aetna Better Health from your list of payers to begin accessing the portal and all of the above features.

Go here to learn more about Availity Portal Registration.

Select here to register.

For registration assistance, please call Availity Client Services at **1-800-282-4548** between 8 AM and 8 PM ET, Monday through Friday.

Secure Provider Portal at a Glance

Our enhanced, secure, and user-friendly web portal is now available. This HIPAA-compliant portal is available 24 hours a day, 7 days a week, and it supports the functions and access to information that you need to take care of your patients. Popular features include:

- **Single sign-on** – One login and password allow you to move smoothly through various systems.
- **Mobile interface** – Enjoy the additional convenience of access through your mobile device.
- **Personalized content and services** – After login, you will find a landing page customized for you.
- **Real-time data access** – View updates as soon as they are posted.
- **Better tracking** – Know immediately the status of each claim submission and medical prior authorization request.
- **eReferrals** – Go paperless. Refer patients to registered specialists electronically and communicate securely with the provider.
- **Automated authorizations** – Depending on the authorization type and service location, it is possible to receive an auto-approval on your request.
- **Detailed summaries** – Find easy access to details about denied prior authorization requests or claims.
- **Enhanced information** – Analyze, track, and improve services and processes.
- **Access to member care** – You can connect to your patients and their care teams. You can access:
  1. A real-time listing of your patients.
  2. Information on your practice.
  3. Email capability with care managers.

Registering is easy!

- Visit our website here and select "For Providers."
- Then, select "Provider Portal.
- At the bottom of the page, select "Log in."

Already have a provider portal account and need help with some of the functionality?

We have an intuitive user guide on the various functions available on our website.

- Go to our website here and select "For Providers."
- Select "Provider Portal," then select "Provider Portal Instructions" at the bottom.

Need help?

We're here for you. Call **1-800-279-1878** and listen for the prompt to Provider Services.

Clinical Inertia in patients with Type 2 Diabetes

A prolonged delay to intensify therapy is known as clinical inertia. Studies have shown that the median time to intensifying therapy in patients with Type 2 diabetes is longer than one year.

Type 2 diabetes is complex disease that requires individualized treatment plans based on patient characteristics to reach A1C goals; and today there are more therapeutic options available to help patients with Type 2 diabetes reach A1C goal.

Early intervention to set and attain A1C goals has many clinical advantages:

- Can help preserve beta cell function
- Extend time to treatment failure.
- Reduce the risk of diabetes related complications

However, up to one half of patients with Type 2 diabetes are not reaching their targeted A1C goals.

There are many challenges when trying to intensify therapy in Type 2 diabetics, and patient barriers may account for up to 30% of the factors contributing to clinical inertia.

Common barriers and strategies to overcome clinical inertia in Type 2 diabetes include:

Barrier	Strategy
Belief disease has worsened	Discuss progressive nature of type 2 diabetes
Injection related anxiety	Demonstrate the needles and injection devices that will be used, provide instruction on needle injection, allow supervised injection rehearsals
Perception that insulin is ineffective	Assure patients that therapy will improve symptoms
Fear of weight gain	Use once daily insulin analogues to minimize weight gain, use insulin in combination with metformin, discuss benefits of other diabetes medication related to weight loss
Fear of hypoglycemia	Use once daily insulin analogues to minimize hypoglycemia risk, use diabetes medications with low risk of hypoglycemia
Fear of injection related pain	Identify patient experience and perceptions related to injections, encourage deep breathing or forceful exhalation during injection

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Discussing resistance to insulin therapy

Open ended questions can help explore patient concerns related to intensifying therapy. Many patients with Type 2 diabetes are particularly hesitant to initiate therapy with insulin. Here are some questions that may facilitate a conversation around initiating insulin therapy:

- How do you think insulin can help with your diabetes?
- Who do you know who has used insulin, and what was their experience?
- What is your greatest concern about using insulin?
- How confident are you that you can inject insulin on a regular basis?
- What information or support do you need to be willing to take insulin injections?

The progressive nature of Type 2 diabetes requires intensifying therapy over time. Identifying patient concerns and barriers towards insulin and intensifying treatment can help reduce the time to reach A1c goals.

References

1. Pantalone K, Misra-Hebert A, Hobbs T, et al. Clinical Inertia in Type 2 Diabetes Management: Evidence from a large, real world data set. *Diabetes Care* 2018;41:e113–e114

2. Cavaiola TS, Kiriakov Y, Reid T. Primary Care management of patients with Type 2 diabetes:overcoming inertia and advancing therapy with the use of injectables. *Clin Ther*. 2019;41:352e367

New RC Claim Assist NDC Tool

Aetna Better Health of Virginia is now offering our provider network a comprehensive resource to assist with submitting medical pharmacy claims. RC Claim Assist, powered by RJ Health, is now accessible to the Aetna Better Health network to provide an easy-to-use resource for correct billing units for medical drug codes.

Benefits of RC Claim Assist

- Provides a broad crosswalk of HCPCS/CPT drug codes, product names, and NDCs
- Reduces number of resubmissions for claims payment
- Contains complete drug information on package size billable units
- Aligns providers and payers on managing medically covered pharmaceuticals

How do I access RC Claims Assist?

1. Select this link and you will be directed to the RC Claim Assist website. Select ***Register***.
2. Enter your billing NPI.
3. Enter your first and last name.
4. Create your Aetna Better Health password.

After registering with your billing NPI, all future logins will use this link. Or, follow this URL.

What are the billing requirements for NDC?

Please refer to pages 127 to 130 of our Provider Manual.

What if an NDC is no longer active?

When billing with NDCs on claims, it is important to ensure that the NDC used is valid for the date of service. This is because NDCs can expire or change. An NDC's inactive status is determined based on a drug's market availability in nationally recognized drug information databases.

Additionally, an NDC is considered obsolete two years after its inactive date. It is recommended to conduct a periodic check of records or automated systems where NDCs may be stored in your office for billing purposes.

To help ensure that correct reimbursement is applied, the 11-digit NDC on your claim should correspond to the active NDC on the medication's outer packaging. Inactive products will continue to be reimbursed until they become obsolete.

If you have any questions on the data on RC Claim Assist, please email **info@rjhealth.com**.

For questions on specific claims issues, please contact Provider Relations at **AetnaBetterHealth-VAProviderRelations@Aetna.com**.

Help Improve Communication between Treating Providers

A recent survey showed that PCPs are concerned because they don't get regular reports about their patients' ongoing evaluation and care from other treating providers.

This breakdown in communication can pose a risk to quality patient care. We know that coordinating care with many providers, facilities, and behavioral health care professionals can be a challenge. Important clinical and mental health information to be shared should include diagnosis, medication, and treatment plans.

Providing consistent information about patients to other providers can improve the overall communication between providers through continuity and coordination of care. Talking with your patients' other health care providers helps you give them the best care. To promote collaboration and holistic care, it's critical that PCPs and specialists talk openly with each other.

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.