Provider Newsletter

Contents

Important Announcements on COVID-19

Aetna Better Health of Virginia now covers the new Johnson & Johnson vaccine, effective **February 26, 2021**:

- CPT code 91303 reimbursed at $.01
- CPT code 0031A reimbursed at $28.39

We have also created a section on our provider website dedicated to updating you on the status of COVID-19 and answering any questions you may have here.

The Department of Medical Assistance has also provided information regarding COVID-19 flexibilities and the COVID-19 vaccine via below memos:

- **Feb 24, 2021:** Update to Reimbursement Rate for COVID-19 Antigen Testing
- **Feb 8, 2021**: Updates to Coverage of High-Throughput COVID-19 Testing
- **Jan 14, 2021**: Update Developmental Disabilities (DD) and Commonwealth Coordinated Care (CCC) Plus Waivers: Provider Flexibilities Related to COVID-19
- **Jan 14, 2021**: COVID-19 Flexibility Continuations Until 4/20/2021
- **Jan 11, 2021**: Implementation of Medicaid Long Term Services and Supports (LTSS) Screening Conducted by Nursing Facilities
- **Jan 7, 2021**: Electronic Visit Verification Live-In Caregiver Exemption and Consumer-Directed Personal Care Overtime
- **Jan 5, 2021**: Pharmacy Procedure For COVID-19 Vaccine

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COVID-19 Vaccine

If one of your patients asks how to get the COVID-19 vaccine and this option is not yet available at your office or facility, there is a hotline now available from the Virginia Department of Health.

Members can call **1-877-VAX-IN-VA** or visit **Vaccinate.Virginia.gov** to pre-register for the vaccine. Language translation and TTY services are available from 8 am to 8 pm. The vaccine is covered at no cost and transportation is available to all Aetna Better Health members who need a ride.

G&A: Proper Billing Codes for Commonly Rejected Claims

Aetna Better Health of Virginia's Appeals and Grievances department consistently strive to uphold and protect the rights of our providers and members. Health care providers can use the Aetna Better Health dispute and appeals process if they do not agree with a claim or utilization review decision.

To initiate an appeal request, we will need:

- A completed copy of the appropriate form.
  - Please fill out the form in its entirety.
  - Only submit one claim per form; each claim needs its own separate form for proper processing.
- The reason(s) why you disagree with our decision.
- A copy of the denial letter or EOB letter.
- The original claim.
- Documents that support your appeal (i.e., medical records and office notes).

To ensure the highest level of provider satisfaction the appeals department tracks trends, we have developed a list of a few examples of trends when filing an appeal:

1. Any services to promote Procreative Management are considered noncovered.
2. CPT code **99072 ADDL SUPL MATRL&STAF TM PHE MEDICINE - SPECIAL SERVICES** requires prior authorization for all lines of business.
3. If you provide a service other than what was originally requested and authorized, contact with Aetna Better Health must be made within 24 hours in order to change the code that had originally been authorized.

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4. If you have an authorization for Community Mental Health Rehabilitative Services, then you must bill using the correct HCPCS code you were authorized for. We are unable to accept the standard behavioral health room and board codes.
4. If you obtain prior authorization for a service, and the service has add-on codes that require prior authorization, you are required to obtain prior authorization for those CPT codes as well.
4. If you have an authorization on file for a specific date range, and the services are performed prior to the authorization date, you must call within 24 hours to change the authorization start date.

We know that some providers have limited administrative assistance. Please take note of these tips and situations in order to minimize the need to file an appeal. Most of these issues can be avoided by contacting our Utilization Management department in a timely manner.

There is also detailed information in Chapter 14 of our Provider Manual. Additionally, you may contact Provider Relations for further assistance at:

- Medallion 4.0/FAMIS: **1-800-279-1878**
- CCC Plus: **1-855-652-8249**

We now have a new PO box for submitting claims, reconsiderations, and appeals:

Aetna Better Health of Virginia
Attn: Appeals Department
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Before filing an appeal, verify that the claim does not qualify to be submitted as a resubmission or reconsideration. A table differentiating an appeal versus a reconsideration can be found in Chapter 14 of our Provider Manual.

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 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 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.

Community Resources for our Members in Need

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.

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.

Warm Lines: A Resource for Members with Mental Health and Substance Use Challenges

Aetna Better Health of Virginia has partnered with AliveRVA and Mental Health America of Virginia (MHAVA) to help our members with mental health and substance use challenges.

AliveRVA and MHAVA offer "Warm Lines" run by Peer Support Specialists, which are non-crisis phone lines where members can call to talk with someone who has real-life experience with mental health issues, substance use, and trauma. Peer Support Specialists are those in long-term recovery who provide a listening ear in a confidential, supportive, and non-judgmental environment.

The Warm Lines can also provide callers with community resources, such as housing, food, transportation, and medical care. Callers can be individuals, families, friends, and providers who deal with mental health and substance use.

AliveRVA Warm Line

The AliveRVA Warm Line is a free peer-run non-profit organization that provides substance use support and is available for all residents of Virginia. Callers will speak with a peer who is in long-term recovery from addiction.

AliveRVA staff can provide health care resources and services that support addiction prevention, treatment, and recovery. Staff can also visit callers in the Richmond metro area after speaking on the phone.

- Phone: **1-833-473-3782**
- Available every day from 8 AM to 12 AM, 365 days a year

MHAVA Warm Line

The MHAVA Warm Line is a free peer-run service for all residents of Virginia. They offer mental health support to individuals, their family, friends, and community.

Staff can talk to callers about concerns related to their mental health and can help with developing hope and recovery. Staff can offer community resources and answer questions about the caller's recovery journey.

- Phone: **1-866-400-6428**
- Available from 9 AM to 9 PM, Monday through Friday, then 5 PM to 9 PM Saturday and Sunday, 365 days a year

Community Health Workers Are Here for Your Patients

What are community health workers (CHWs)?

CHWs are trusted members of the community. Aetna Better Heath of Virginia works with CHWs to serve as a link between the community and our members' health. CHWs improve members' ability to manage their health through a series of activities, including:

- Outreach.
- Education.
- Informal counseling.
- Social support.
- Advocacy.

With the help of CHWs and our care managers, we can help members get the community resources that they need. CHWs can also support members with making appointments.

What are the goals of CHWs?

- Support members in achieving health goals
- Improve access to care
- Improve member health care engagement
- Reduce unnecessary hospitalizations and ER visits
- Provide services that fit members' culture, language, and religion
- Connect members to resources in the community

What services do CHWs offer?

CHWs meet with members regularly via home visits, outpatient settings, and hospitals to assist with their care plan goals. They also:

- Help members understand the nutritional value of food and meal selection.
- Teach members disease management strategies.
- Assist members in using community services.
- Aid in scheduling appointments with social services.

Also, CHWs educate health care providers. They find opportunities for improving and understanding personal challenges that may affect member health.

How do CHWs benefit your care?

CHWs can benefit member care by increasing communication and participation with services. They can also encourage members to attend health care appointments. Additionally, CHWs can help members:

- Stay out of the ER and hospital.
- Follow medication plans and provider recommendations.
- Understand their physical health.

If you have any Aetna Better Health of Virginia members that could benefit by having a CHW, please have them call their care manager or Member Services at **1-800-279-1878** (**TTY: 711**).

Key Update: Chronic Obstructive Pulmonary Disease and Inhaled Corticosteroids

The Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2019 introduced blood eosinophil counts as a biomarker for estimating efficacy of inhaled corticosteroids (ICS) in prevention of exacerbations.

The 2020 GOLD initiative added information regarding the role of eosinophil count as a biomarker along with clarification of the diagnosis of exacerbations.

Exacerbations represent the main clinically relevant endpoint when assessing the anti-inflammatory efficacy of a drug.

A key point is that **long-term use of ICS monotherapy is not recommended in COPD**, as most studies are finding regular treatment with an ICS alone is does not affect the long-term decline of FEV1, nor does it show improvements in patient mortality rates.

ICS in Combination with Long Acting Bronchodilator Therapy

For patients having moderate to severe COPD with exacerbations, the combined use of an ICS and a Long Acting Beta Agonist (LABA) has been found to be more effective than either of these components alone.

At higher blood eosinophil concentrations, in populations with high exacerbation risk (>2 exacerbations or 1 hospitalization per year), use of ICS/LABA decreases exacerbations to a greater extent than use of a Long Acting Antimuscarinic (LAMA) monotherapy or a LABA/LAMA combination.

Improvements are noted in:

- Lung function
- Health status.
- Reduction of exacerbation.

When to Add ICS for Combination Treatment of COPD Management

- History of hospitalization for exacerbations of COPD
- Two or more moderate exacerbations of COPD/year
- Blood eosinophils ≥300 cells/microliter
- History of asthma, or concomitant asthma

Stepwise Progression Guide to Pharmacological Treatment

- Zero or one moderate exacerbation (not leading to hospital admission):
  - **Group A: Minimally symptomatic – low risk of exacerbation**
- Bronchodilator (either SABA or LABA)
  - **Group B: More symptomatic, low risk of exacerbation**
    - » LABA or LAMA
- Two or more moderate exacerbations OR one or more leading to hospitalization:
  - **Group C: Minimally symptomatic, high risk of exacerbation**
    - » LAMA
  - **Group D: More symptomatic, high risk of exacerbation**
    - » LAMA
    - » LAMA and LABA
      - Patient is highly symptomatic with COPD Assesssment Test (CAT) >20
    - » ICS and LABA
      - Patient's blood eosinophils ≥300 cells/microliter

Pharmacy Limitations, Injectables, and Step Therapy

Aetna Better Health of Virginia applies quantity limits on medications to ensure safety, promote cost-effective dosing and deter waste and abuse. Quantity limits are reviewed and set based on the FDA-approved dosing and medically accepted uses.

Our step therapy program requires certain first-line drugs, such as generic drugs or formulary brand drugs, to be prescribed prior to approval of specific second-line drugs.

Drugs having step therapy are identified on the formulary with "STEP." Certain drugs on our formulary have quantity limits and are identified on the formulary with "QLL."

For example, medications FDA-approved for once daily administration are typically limited to one dose per day. Some medications may additionally be limited at a specified quantity per fill.

To view our listing of noncovered drugs, step therapy requirements, pharmacy prior authorization requirements, or to request a drug that isn't in our formulary, review the Provider Manual or contact the Pharmacy Department at **1-800-279-1878** (Medallion 4.0/FAMIS) or **1-855-652-8249** (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**

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.

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**.