Quality HEDIS® Toolkit

Aetna Better Health® of Virginia

AetnaBetterHealth.com/Virginia

VA-22-06-10

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Welcome

Welcome to Aetna Better Health of Virginia.

Thank you for joining Aetna Better Health of Virginia!

As the Director of Quality for Aetna Better Health, I would like to personally welcome you to our health plan. Quality is a high priority for Aetna Better Health, especially in ensuring that our members receive excellent and timely care.

The Healthcare Effective Data and Information Set (HEDIS®) is one of the measurements that is used for quality improvement processes and preventative care programs. Aetna Better Health needs your participation to improve HEDIS measures. HEDIS assists providers in identifying and eliminating gaps in care for members.

Our goal is for providers to submit claims and encounters with coding that administratively captures all required HEDIS data, which decreases or removes the need for medical record reviews.

I hope that this toolkit provides you with the necessary resources to support you in completing this task.

If you have questions, need clarification, or require additional support, reach out to your Network Relations Representative.

Again, welcome!

Zoe Ann Amey-McCleary

NCQA defines HEDIS as “a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of health care plans.” HEDIS is a registered trademark of the National Committee for Quality Assurance.

Healthy Happens Together

Aetna Better Health is focused on serving our members at the local level with a fully integrated care model that includes physical health, behavioral health, and social determinants of health. Our history and experience demonstrate our total commitment to achieving a healthier population in the communities we serve.

Aetna Better Health's network of providers has been carefully selected based on their exemplary service to its members. Aetna Better Health is committed to ensuring that the providers receive the best possible information and feedback to guarantee their continued success.

Our HEDIS Outreach Coordinators

- HEDIS Outreach Coordinators assist with provider and member outreach by making sure members receive important clinical services to improve their overall health.
- They provide support for HEDIS quality initiatives and aid in medical record review.
- In addition to hybrid abstraction, HEDIS Outreach Coordinators also abstract supplemental data to identify members who are noncompliant.
- Quality has designated outreach services that develop and maintain member incentive programs to support HEDIS initiatives.

HEDIS Toolkit

A key component of achieving superior health care and satisfaction for members is the doctor-patient relationship. Members who have a positive relationship with their health care provider are more likely to seek appropriate care. Our programs seek to enhance this relationship and support our members toward the highest quality health care, as measured by national benchmarks. All of our quality measures at Aetna Better Health are Healthcare Effectiveness Data and Information Set (HEDIS®) focused.

Some fast facts:

- HEDIS is a performance measurement tool that is coordinated and administered by NCQA and used by the Centers for Medicare and Medicaid Services for monitoring the performance of managed care organizations.
- Results from HEDIS data collection serve as measurements for quality improvement processes, educational initiatives, and preventive care programs.
- All managed care companies who are NCQA-accredited perform HEDIS reviews the same time each year.
- HEDIS is a retrospective review of services/performance of care from the prior calendar year.

There are two types of HEDIS data collected:

- **Administrative data** comes from submitted claims and encounters.
- **Hybrid data** comes from chart collection/review.

HEDIS Medical Record Review Process:

Feb – Early May: The Quality Department collects and reviews HEDIS data. (Onsite provider office chart collecting occurs at this time.) Data collection methods include fax, mail, onsite visits for larger requests, and remote electronic medical record system access if available.

June: HEDIS results are certified and reported to NCQA.

October: NCQA releases Quality Compass results nationwide for Medicaid.

HEDIS Tips and Best Practices

Tips and Best Practices

General tips and information that can be applied to most HEDIS measures:

- Use your member roster to contact patients due for an exam or are new to your practice.
- Use this guide, coding information, and other resources to educate the staff regarding HEDIS compliance and requirements.
- Use your Gaps in Care member list to outreach to patients in need of services/procedures.
- Provide evidence of completed HEDIS services and attach the supporting chart documentation upon contacting the Quality Management department.
- Schedule the members' next well visit or follow-up at the end of each appointment.
- Each office should have a HEDIS subject matter expert who performs internal reviews and serves as a point of contact for managed care organizations and their staff.
- Set up electronic health records with HEDIS flags that alert the staff of patients in need of these essential HEDIS services.

HIPAA

Under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, data collection for HEDIS is permitted, and the release of this information requires no special patient consent or authorization.

Be assured our members' personal health information is maintained in accordance with all federal and state laws. HEDIS results are reported collectively without individual identifiers or outcomes. All of the health plans' contracted providers' records are protected by these laws.

HEDIS data collection and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities. The records you provide us during this process help us to validate the quality of care our members received

HEDIS Tips and Best Practices

Importance of Documentation

Adherence to principles governing the medical record and proper, appropriate documentation:

- Enables providers and other health care staff to evaluate a patient's health care needs and assess the efficacy of the treatment plan.
- Serves as the legal document to verify the care rendered and date of service.
- Ensures date care was rendered is present and all documents are legible.
- Serves as a communication tool among providers and other health care professionals involved in the patient's care, for improved continuity of care.
- Facilitates timely claim adjudication and payment.
- Will reduce many of the "hassles" associated with claims processing and HEDIS chart requests.
- ICD-10 and CPT codes reported on billing statements should be supported by the documentation in the medical record.

Important Links

CTP II codes reported are used for monitoring performance during the year and assist in closing gaps in care. Access the links below to obtain more information about CPT II codes and HEDIS:

HEDIS measures and descriptions
HEDIS Billing Quick Reference Codes
HEDIS CPT II Codes for HEDIS

HEDIS Quick Reference Billing Codes

This HEDIS Billing Codes Quick Reference Guide is a tool for providers, as well as their clinical team, and billing staff. It includes helpful information used to improve HEDIS performance.

Disclaimer

This material serves as a tool to assist providers, their clinical team, and billing staff with information to improve HEDIS performance. This guide to HEDIS documentations includes a number of HEDIS measures, not all of which are used in the Quality Incentive Programs. They can help your practice to achieve improved HEDIS scores, an important goal for all primary care providers independent of incentives.

The NCQA HEDIS Technical Specifications for Health Plans was used to generate this provider guide. The Technical Specifications were current at the time of publication. HEDIS indicators have been designed by NCQA to standardize performance measurement and do not necessarily represent the ideal standard of care. Information contained in this report is based on claims data only.

To access the HEDIS Billing Codes Quick Reference Guide, select here. Then, click on the downward facing arrow to access the toolkit at the bottom of the page.

EPSDT Advocacy

Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) is a comprehensive and preventive child health program for individuals under the age of 21 who receive Medicaid through Medicaid/FAMIS Plus or a managed care organization. There is no separate application or enrollment process. The goal of EPSDT is to screen, identify and treat issues as early as possible to promote healthier outcomes for our children.

To access the EPSDT Toolkit, select here.

Social Determinants of Health

Social Determinants of Health (SDOH) are defined as conditions in places where people live, learn, work, and play that affect a wide range of health risks and outcomes.

Identification and tracking of SDOH allow health care provider to better track patient needs and identify solutions to improve the health of their communities.

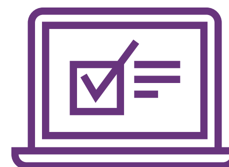
To access the SDOH Toolkit, select here.

Reporting

Quality will have the following reports available to provide to provider offices:

Gaps in Care Reports

- These show, by measure, which members on your panel have not completed the measure.
- These reports **do not** provide aggregate results.
- Data is reported at the measure level by member.



“All in” for Our Members

Aetna Better Health members have a variety of additional health care benefits and services available to them and are outlined in the Member Handbook.

- To access the Member Handbook, select here.

Additional benefits that our members can take advantage of can also be found on our website. Visit our website here to see the benefits Aetna Better Health has to offer.

Here is a snapshot of some of our added benefits that are exclusive to Aetna Better Health members:

Vision care: One eye exam and $250 toward eye ware.

Hearing care: One hearing exam, $1,500 toward hearing aids, plus 60 batteries each year, plus unlimited visits for hearing aid fittings.

Home meal delivery: Home-delivered meals after hospital discharge for seven days.

Over-the-Counter Health Solutions® period stipend: $20 monthly for members with periods to spend on the member’s choice of period products through CVS Pharmacy®.

New Moms Stipend: $25 monthly for eligible members who are pregnant through one year postpartum to spend on over-the-counter items for them and their baby through CVS Pharmacy.

Healthy food card: Eligible members can get money added to a special debit card. The card can be used to buy healthy groceries at nearby stores.

Extra help with rides: Members who need help with getting to local resources or services can enjoy free rides — up to 30 round trips or 60 one-way trips each year.

Rewards: Members can get gift cards for taking care of their health.

- Kids also get extra perks, like free swimming lessons and sports physicals, plus up to a $25 gift card when they join the Ted E. Bear, M.D.® Wellness Club!
- Baby showers for our new moms

To learn more about specific community events and partnerships, reach out to VAOutreach@Aetna.com.

Pharmacy Review/Guidance

We understand that getting members the prescription drugs they need is an important part of their health care, and we want to make it as convenient for you as possible.

Aetna Better Health and Pharmacy Benefit Manager (PBM) Number(s)	Aetna Better Health phone numbers: • Member Services: **1-800-279-1878**, option 1 PBM numbers: • CVS Mail Order: **1-855-271-6603** • CVS Specialty Pharmacy: **1-800-237-2767**
Formulary Information	**AetnaBetterHealth.com/Virginia/providers/pharmacy.html**
Pharmacy Prior Authorization (PA)	• Hours of operation for provider PA calls is 8AM to 5PM EST. • Fax and ePA requests can be submitted 24 hours/day, 7 days a week. • PA forms can be accessed here and PA criteria can be accessed here.* Cover My Meds can be accessed here and their toll-free number is **1-866-452-5017**. SureScripts can be accessed here and their toll-free number is **1-866-797-3239**. Submit PA via phone: • Legacy M4 PA: **1-800-279-1878**, option 6, option 4, option 1 • Legacy Plus PA: **1-855-652-8249**, option 3, option 6, option 1 Submit PA via fax: • **1-855-799-2553**
Transition of Care	Most medications that require PA or are nonformulary will be offered one (up to a 34 day supply) transition fill during the first 90 days with Aetna Better Health. Transition fills are not allowed at mail order.
Durable Medical Equipment	The following are covered through pharmacy: • Peak flow meters; QLL=#2/year • One Touch Glucometers and diabetic supplies (lancets and insulin syringes); QLL for test strips = 5/day; QLL for meters=1/year
Vaccines	Vaccines for children (under 19 years of age) are not covered through the pharmacy benefit outside of FAMIS.

Care Management Program

Aetna Better Health offers a care management program for patients who need extra support on their health journey. This program offers patients the ability to connect with a care manager to identify and work on health goals.

The program does not provide medical care; instead, it helps advocate for care most appropriate for their individual needs. The care manager will work closely with the provider's office to coordinate the provider's care plan and offer resources that best manage the member's health. The care manager can meet with patients where they are comfortable, including at home or work. The care manager will discuss patient needs and connect them with community-based resources, such as housing, food insecurity, and even employment opportunities.

In addition, the care manager can connect patients with other Aetna Better Health team members, including pharmacists, dietitians, community health workers and behavioral health specialists.

Aetna Better Health offers disease management to members with the following conditions:

- Asthma
- Congestive heart failure
- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Chronic renal failure
- Coronary artery disease
- Depression

To refer a member for these services, have them call Member Services at
1-800-279-1878 (TTY 711).

Provider Resources

Provider Relations

The Provider Relations department serves as a liaison between the health plan and the provider community. All providers can reach out to the health plan by calling **1-800-279-1878**. The voice prompts will direct the caller to the different areas with the health plan that can help. Providers can connect with their assigned Network Relations Consultant for escalated issues by emailing **AetnaBetterHealth-VAProviderRelations@Aetna.com**. The Network Relations Consultants will then work with you to resolve any issues you may be experiencing.
Some of the everyday actions taken to help providers include:

- Provider education.
- Keeping track of member updates.
- Locating forms.
- Reviewing member information.
- Checking member eligibility.
- Finding a participating provider/specialist.
- Submitting a prior authorization.
- Reviewing/searching the Preferred Drug List.
- Notifying us of a provider termination.
- Notifying us of changes to your practice.
- Advising a tax ID or NPI number change.
- Obtaining a secure web portal or member care login ID.
- Reviewing claims or remittance advice.

Provider News and Notifications

Aetna Better Health communicates with providers through the Aetna Better Health website. To access provider news, notifications, and the Provider Newsletter, go here.

Provider Manual

To review the Aetna Better Health provider manual, go here and select **Provider Manual**.

Provider Portal

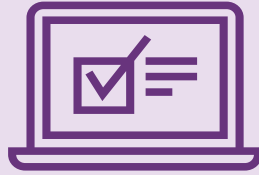
Aetna Better Health's Provider Portal is free to use and lets you securely access critical information conveniently online whenever and wherever you need it. The Provider Portal is available for you to directly connect with us for up-to-date information including:

- Eligibility verification.
- Claims inquiries.
- Prior authorization information and requests.
- Remittance advices.

To access the Provider Portal, to download the registration form, and to review the Provider Portal instructions, go here and select **Provider Portal**.

Participating Provider Quick Reference Guide

Helpful Web Links



Our Provider Website

Provider Manual

Updates, Announcements, and our Newsletter

Secure Provider Portal (Registration is required)

Provider Relations

Call Provider Relations for provider-related inquiries and to reach Claims Status, Inquiries or Research (CICR), Pharmacy, Prior Authorizations, and Member Services:
Phone: **1-800-279-1878 (TTY: 711)**
Fax: **844-230-8829**
Email: **AetnaBetterHealth-VAProviderRelations@Aetna.com**

Contracting and Credentialing

For all contracting inquiries, email the Contracting team at **NetworkDevelopment-VAContact@aetna.com**.

To submit your request to become a participating provider with Aetna Better Health, visit our website.

Pharmacy

To review our Formulary Drug List, prior authorization (PA) criteria, PA forms, and how to submit an electronic PA, providers can visit the Pharmacy section of our website.

The fax for PAs is **1-855-799-2553**.

Claims

Claims Submissions

All claims must be submitted with the following:

- Member's name, date of birth, and ID number
- Service/admission date
- Location of treatment
- Service or procedure

Learn more about claims.

Timely Filing Limits

- Medical claims must be submitted within 365 calendar days from the date of service or discharge. The claim will be denied if not received within the required timeframes.
- Corrected claims must be submitted within 365 days from date of service.
- Coordination of Benefits claims must be submitted within 365 days from date of member's EOB.

Electronic Claims Submissions

- WebConnect is our free provider claims submission portal via Change Healthcare (Emdeon)
- To set up free "Eligibility and Submission of Claims" services, visit physician.connectcenter.changehealthcare.com/#/site/home and select "Sign Up. Enter vendor code 214557.
- For WebConnect support, call **1-877-667-1512**
- EDI payer ID (837 Claim): 128VA
- To get real time eligibility/claim/auth. inquiry use ID: ABHVA (270/271; 276/277; 278)

Paper Claim Submissions

Aetna Better Health of Virginia
Attn: Claims Department
PO Box 982974, El Paso, TX 79998-2974

Appeals

Submitted within 60 days of original denial. Fill out the the Authorization Release for Standard Appeal form and fax this form with your appeal.

Learn more about Grievances and Appeals.

Provider Appeals

Aetna Better Health of Virginia
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Member Appeals

Aetna Better Health of Virginia
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

Aetna Better Health® of Virginia

Medical and Behavioral Health PAs

Fax for Legacy M4: **866-669-2454**
Fax for Legacy Plus: **855-661-1828**
Behavioral Health: **833-757-1583**

To determine if a service requires PA, visit the Provider Portal. When requesting PA, include the following:

- Member's name and ID number
- Date of birth
- 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 PA; however, notification is required the same day.

For post stabilization services, hospitals may request prior authorization by calling the 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.

Participating providers can now check for codes that require prior authorization via our Online Prior Authorization Search Tool. View the tool here.

Other Important Contacts

Mental Health Assistance

Phone: **1-800-279-1878**, press * then option 1
For Addiction Recovery Treatment Services (ARTS) forms, visit our Materials and Forms page on our website.

Consumer Direction

For all Consumer Direction care inquiries (authorization/ PPL concerns, service facilitation questions, attendant pay, and timesheets), email **AetnaConsumerDirection@aetna.com**.

Fax: **1-844-459-6680**

Pain Management/ Radiology (eviCore)

Phone: **1-888-693-3211**
Fax: **1-844-822-3862**

Case Management

Our Case Management program can help reduce barriers to care for your patients. To learn more, call Member Services: **1-800-279-1878 (TTY: 711)**.

Transportation (Modivcare)

Phone: **1-800-734-0430**

Transportation to and from provider offices is a covered benefit for all members who do not have access to transportation. Members must call at least three days prior to their scheduled appointment to arrange transportation.

Vision (VSP)

Phone: **1-800-877-7195**
Website: **www.vsp.com**

Virtual Credit Card (VCC)

For VCC inquiries or request, contact Change Healthcare (Emdeon) Card Service Department at **1-855-723-3475**.

If you wish to opt out of the Virtual Card Payment Program, consider enrolling in EFT/ERA Registration Services (EERS) through Change Healthcare. To enroll in EERS, visit PayerEnrollServices.com.

COVID-19 Billing Reference Guide

We have developed a COVID-19 Billing Reference guide based on guidelines from the Virginia Department of Medical Assistance Services (DMAS). Aetna Better Health of Virginia will cover medically necessary services to treat or alleviate symptoms related to COVID-19.

Access this guide here.

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