AETNA BETTER HEALTH® OF VIRGINIA
Provider Newsletter

Fall 2016

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New Aetna Better Health® of Virginia provider agreements are now available

Be on the lookout for a new provider agreement in your mailbox to replace your current CoventryCares of Virginia agreement. Don't worry, your current Coventry agreement remains in place and your participation continues in a seamless manner. We are simply updating your agreement to reflect our new name, Aetna Better Health of Virginia.

Please contact **NetworkDevelopment-VAContact@aetna.com** if you have any questions regarding the new document.

Reminder on balance billing

Are you preparing to bill a Medicaid and/or FAMIS member? If so, please remember the following:

Aetna Better Health of Virginia participating providers are prohibited, by contract, from billing members for any balance of payment other than co-pays for covered services, or as otherwise permitted under applicable law. Providers accept reimbursement from Aetna Better Health in full.

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A provider may seek reimbursement from a member when a service is not a covered benefit and the member has given informed written consent before treatment that they agree to be held responsible for all charges associated with the service.

In addition, providers may not bill or take other recourse against the member, the member's family, or the member's guardian for claims denied as a result of error attributed to the provider or claims processing entity. This rule applies to providers that participate in Aetna Better Health of Virginia's network and out of network providers. The number one highest volume of member complaints is balance billing issues.

If a member reports that a provider is balance billing for a covered service, the provider will be contacted by an Aetna Better Health provider relations representative to research the complaint. Aetna Better Health is obligated to notify the Virginia Department of Medical Assistance Services (DMAS) when a provider continues the inappropriate practice of balance billing a member.

Login or register for our provider portal today. It's easy!

Our free provider portal allows you to securely access critical information online wherever and whenever you need it. This innovative tool is available to connect you directly with up-to-date information, including:

- Eligibility verification
- Claims inquiries
- Prior authorization information and requests
- Remittance advices
- And other helpful information

Popular features include:

- Mobile interface: Enjoy the additional convenience of access through your mobile device
- Real-time data access: View updates as soon as they are posted
- Better tracking: Know immediately the status of each claim submission and medical PA request
- Enhanced information: Analyze, track, and improve services and processes
- Member details: Access member details containing eligibility, PCP, and co-pay information

Registering is easy

1. Visit **www.aetnabetterhealth.com/virginia**
2. Click "For Providers"
3. Select "Provider Portal," then click "Login"

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.

1. Visit **www.aetnabetterhealth.com/virginia**
2. Click "For Providers"
3. Select "Provider Portal," then click "Provider Portal Instructions"

Need help?

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

Screening adolescents for depression

It is difficult to diagnose depression in adolescents, due to teens' normal mood changes. Please screen your adolescent patients for mood disorders, including depression and refer them for treatment, as appropriate.

Help keep asthma patients out of the ER

Flu season is upon us. Encourage your asthma patients, including parents and children, to get a flu shot. Are your patients using their prescribed asthma controller medication(s)? Monitor the need for rescue interventions and adjust controller medications as necessary.

Healthy babies, healthy moms

To ensure our new mothers stay well and complete their postpartum follow-up visit in a timely manner (21-56 days after delivery), Aetna Better Health of Virginia offers a maternity incentive program. Each new mom is also sent a postpartum packet in the mail. This packet gives members detailed information on when to schedule postpartum visits with their provider in order to promote a healthy outcome after delivery.

To request a sample postpartum packet for your office, contact your Provider Relations representative today. And thank you for providing the necessary care for our new moms!

Provider Manual: Your Information Source

Our provider manual is reviewed annually, at a minimum, and is updated as needed. Your provider manual is a primary information source and an effective guide to your participation with us.

The 2016 provider manual is available on our website. Visit **www.aetnabetterhealth.com/virginia**, click "For Providers," then select "Provider Manual" in the left navigation. Please refer to this edition only and discard any previous versions you may have on hand. Our 2017 provider manual will soon be available.

Our provider manual is created in a format that allows you to find the information you need quickly. In the Table of Contents, simply click on the desired section or topic to be taken to the appropriate page. Please take time to review this manual with your staff.

Contact your provider relations representative at **1-800-279-1878** with any questions.

Understanding the importance of complete medical records documentation

Documentation in a patient's medical record should include all documentation that relates to the care of the patient during the patient's encounter.

This is important in order to bill appropriately. Documentation forms the basis for correct coding and subsequent bill submission.

We are required to audit our providers. If audited for fraud, waste or abuse, the medical records must have the supporting documentation for the codes that are billed.

Integrated Care Management

Program description

Our Integrated Care Management (ICM) program was developed as a way to help our members who have complex needs. Often members need help and support for a variety of reasons: they may not have family close by; they may have trouble managing chronic illnesses; they may need connections to community services or supports; they may need education about their condition – or for any other reason. This program can help!

How Integrated Care Management works

Integrated Care Management is a collaborative process that includes chronic condition management at all levels of care in which a health care team:

- Assesses an individual's health care needs
- Plans, implements, coordinates and monitors options and services to meet those needs
- Continuously evaluates results and adjusts the plan of care accordingly

The goal is to promote quality, cost-effective outcomes. With the help of our dedicated providers, Aetna Better Health can improve access to high quality care for our members who have highly complex conditions, while avoiding unnecessary medical costs.

Providers, nurses and plan staff work together to identify those who may benefit from care management. Aetna Better Health identifies members who might benefit from care management by several means, including health risk assessments and data screening. Members can also self-identify, and families can make referrals. We then work with providers and the member to set attainable and measurable health care goals the member can reach.

All members have access to a care manager

Care managers (CM) typically are registered nurses or social workers. The CM works with you, the member, caregiver and/or family to come up with a plan of care that meets the member's needs. How much help a member receives depends on the individual.

Guidelines for provider referrals to the ICM program

You may want to refer a member to Aetna Better Health care management when he or she:

- Goes to the emergency room instead of visiting your office for ongoing issues
- Has had more than one hospitalization recently
- Has difficulty obtaining medical benefits ordered by providers
- Has been diagnosed with a chronic condition such as heart failure, diabetes, asthma, or COPD, and needs additional support with his or her treatment plan
- Needs help applying for a state-based, long-term care program
- Has been diagnosed with HIV
- Has a high-risk pregnancy
- Is pregnant and over 35 years of age
- Has been referred to a specialist, but needs help with next steps
- Needs information on available community services and resources not covered by Medicaid (e.g. energy assistance, SNAP, housing assistance)

To make a referral for care management consideration, just call Provider Services at 1-800-279-1878. Members can also self-refer for care management. You should get a response from a CM within three to five business days.

What happens after your referral?

Registered nurses, social workers and counselors, as well as non-clinical professionals, will help determine the member's individual risks and overall health care needs.

Typically, a health plan staff member will call to make initial contact with the member and explain the program. The CM may also contact the member's caregivers or others as needed.

Next steps: We develop a care plan

To help the member learn how to meet the multilevel health care needs that typically surround his or her illness, the CM will complete a health risk assessment. The CM will ask questions to help determine:

1. The member's physical and mental health
2. What environmental/social factors may be having an impact on the patient's health
3. What resources he or she is currently using

Answers to these questions help the CM determine what kinds of assistance the member needs most.

Next, the member and the CM work together to develop a quality-focused, cost-effective care plan. The CM will educate the member on his or her condition and how to obtain what he or she needs. The CM will also stress the importance of staying on the treatment plan. This can help prevent worsening of the condition or any complications.

In addition, the CM will work with the member's health care providers to help coordinate any unmet needs. How much care and how often the CM needs to visit with the member (and/or caregivers) will vary based upon the member's individual health care situation. The goal is to improve the member's health and well-being as much as possible.

ICM programs include, but are not limited to:

- Pregnancy outreach and high-risk OB
- Chronic condition management
- Special health care needs
- Behavioral health/substance abuse

Please note that a member may self-refer into a program or opt out of care management at any time.

If you have any questions about our ICM program, we're here to help. Just give us a call at **1-800-279-1878** and ask for the care management department.

Our chronic condition programs target specific illnesses

Our chronic condition programs help members stay healthy. Members learn about their illnesses and how to stay well by working with their providers. Our program includes regular communications, targeted outreach and support, and focused education.

We currently have programs for asthma, diabetes, COPD, coronary artery disease, heart failure and depression. Members receive education, coaching and other services to help them better manage their condition. They also receive action plans, and have access to dedicated clinicians.

Before developing an action plan for any member, clinical staff will perform a health risk assessment. They then discuss and agree on an action plan together with the member. That may include recommendations for:

- Equipment or supplies
- A referral for specialty care
- Other special considerations due to co-morbidities, including behavioral health and substance abuse

We encourage providers to refer patients who would benefit from chronic condition management. To refer one of our members, just call us at **1-800-279-1878** (Monday-Friday, 8 AM-5 PM).

Please note that members may opt in or opt out of a chronic condition program at any time. All they need to do is notify us at **1-800-279-1878**.

If you have any questions about any of our chronic condition programs, just give us a call at **1-800-279-1878**.

Provider office hours of operation disparity

Aetna Better Health requires that network practitioners offer the same hours of operation to all members, regardless of line of business. Providers are prohibited from discriminating against Medicaid members.

Aetna Better Health® of Virginia
9881 Mayland Drive
Richmond, VA 23233-1458

AETNA BETTER HEALTH® OF VIRGINIA

Quick Reference Guide

Effective April 1, 2016

CLAIMS AND RESUBMISSIONS

Aetna Better Health of Virginia requires clean claims submissions for processing

To submit a clean claim, the participating provider must submit:

- Member's name
- Member's date of birth
- Member's identification number
- Service/Admission date
- Location of treatment
- Service or procedure

Timely filing changes needed:

- For 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 the date of service.
- Coordination of Benefits (COB) claims must be submitted within 365 days from the date of primary insurer's Explanation of Benefits (EOB).

MEMBER SERVICES

Member Eligibility, PCP Assignment Changes, Interpreter Request **1-800-279-1878**

PRIOR AUTHORIZATIONS

Aetna Better Health
1-800-279-1878
To determine if a service requires prior authorization, visit **www.aetnabetterhealth.com/virginia**

Radiology (eviCore)
1-888-693-3211 Fax: **1-888-693-3210**

Pain Management (eviCore)
1-888-393-0989 Fax: **1-888-229-5680**

Smiles for Children (Dental)
1-888-912-3456

When requesting 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 **1-800-279-1878**. All out of network services must be authorized. Unauthorized services will not be reimbursed and authorizations are not a guarantee of payment.

ELECTRONIC CLAIMS SUBMISSION

Change Healthcare (Emdeon)
1-877-363-3666
www.changehealthcare.com

EDI payor ID (837 Claim): 128VA

To get real time eligibility/claim/auth inquiry use ID: ABHVA (270/271; 276/277; 278)

PAPER CLAIM SUBMISSIONS

Mailing Address
Aetna Better Health of Virginia
Attn: Claims Department
P.O. Box 63518
Phoenix, AZ 85082-3518

ENROLLMENT

1-800-279-1878

APPEALS

Submitted within 30 days of original denial

Mailing Address
Aetna Better Health of Virginia
Attn: Appeals Coordinator
9881 Mayland Dr
Richmond, VA 23233

CONTRACTING AND CREDENTIALING

Please submit your request to become a partner with
Aetna Better Health on our website at
www.aetnabetterhealth.com/virginia

BEHAVIORAL HEALTH

1-800-279-1878

To locate a participating provider, use our online search tool at **www.aetnabetterhealth.com/virginia**

SECURE PROVIDER PORTAL

- Get eligibility, benefits, referrals and claims info
- Use our payment estimator and submit claims
- View EFT and remittances

aetnabetterhealth-Virginia.aetna.com

OTHER IMPORTANT CONTACTS

Smiles for Children (Dental)
1-888-912-3456

Vision (VSP)
1-800-877-7195
www.vsp.com

Transportation (Logisticare)
1-800-734-0430

Members must call at least three days prior to schedule an appointment to arrange transportation

Pharmacy
Our online formulary can be viewed at
www.aetnabetterhealth.com/virginia
1-800-279-1878 Fax: **1-855-799-2553**

Provider Relations
1-800-279-1878
Aetnabetterhealth-VAProviderRelations@aetna.com

ID CARDS