Has your information changed?

Aetna Better Health of Virginia is committed to having the most accurate and up-to-date information in our system for you and your provider group. Please contact Provider Services at **1-800-279-1878** (Medallion/FAMIS) or **1-855-652-8249** (CCC Plus) with any updates to your phone and fax numbers, physical, billing, or office mailing addresses, and to add your email address to our system.

Have a question about a claim?

If you have a question about a claim, our Claim Inquiry Claims Research (CICR) team can help. CICR is a valuable resource and many claims issues can be researched and resolved via this option, including:

- Member benefits and eligibility
- Claim status/payment
- Remittance advices
- Authorization inquiries

How to contact CICR?

Program	Phone number
Medallion/FAMIS	1-800-279-1878
CCC Plus	1-855-652-8249, option 4, then press 5
HMO-SNP	1-855-463-0933, option 4, then press 3

Continued...

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Provider appeal of claim action
Providers may appeal any adverse claim action from the date of the adverse claim determination within 60 calendar days.

Prior to appealing a claim action, providers may contact CICR for claim information. In many cases, claim denials are the result of inaccurate filing practices.

Other ways CICR can assist our provider community

- Billing and coding
- Check tracers
- Pay to issues
- Contract disputes
- Pay denial reconsiderations
- Address changes
- COB
- Remits

Type of Bill reminder

The National Uniform Billing Committee (NUBC) maintains the Type of Bill code set for use on institutional claims by the healthcare industry. Revisions in October 2013 simplified the code set by using one Type of Bill code for all home health services provided under a home health plan of care. Additionally, Medicare updated the home health chapter of Publication 100-04, Medicare Claims Processing Manual, to discontinue the use of bill type 33X and instruct home health providers to use 32X.

- 033X Type of Bill was discontinued as of October 7, 2013.
- 032X Type of Bill was redefined to mean "Home Health Services under a Plan of Treatment."

For additional resources on this change, consult the 2015 NUBC Official UB-04 Data Specifications Manual, or consult CMS transmittal 2694 at: **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2694CP.pdf.**

New admissions fax number: Update your systems immediately!

In order to serve you more expeditiously, we now have a fax line dedicated solely to inpatient notifications/admission authorizations, clinical information related to a continued stay, discharge notification or summaries, etc. This fax line may be used for all lines of business and anything related inpatient or observation requests.

The new fax number is **877-817-3707** for the requests mentioned above. If you have any questions, please call the appropriate Member Services number listed below:

Program	Medallion	CCC Plus	HMO-SNP
Phone	1-800-279-1878 (TTY: 711)	1-855-652-8249 (TTY: 711)	1-855-463-0933 (TTY: 711)
Hours	24 hours a day, 7 days a week	24 hours a day, 7 days a week	8 a.m. - 8 p.m., 7 days a week
Outpatient Prior Authorization FAX	855-661-1828	855-661-1828	833-280-5224
Inpatient Prior Authorization FAX	877-817-3707	877-817-3707	877-817-3707

You can also request prior authorization on our website
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.

Application Process

If you are interested in contracting with Aetna Better Health of Virginia, a Letter of Interest (LOI) should be emailed to **AetnaBetterHealth-VAProviderRelations@aetna.com**. If you have any questions about the process, you may also use the same email address.

In the subject line, please add **Request to join network**.

Alternatively, you may fax us at **844-230-8829**.

The LOI should be on the provider's letterhead and must include the following:

- Enrolled in DMAS with active DMAS ID number
- Medicare ID number (if applicable)
- Geographic location
- Provider specialty and services/facility
- Point of contact (name, phone and email)

Please allow three business days to receive a response and/or application packet.

How to contact your Network Relations Consultant

Our Provider Relations Department supports multiple functions in network development and contracting.

This includes evaluation of the provider network and compliance with regulatory network capacity standards. Our staff is responsible for the creation and development of provider training, education and communication materials, including the provider manual, periodic provider newsletters, bulletins, fax/email blasts, website notices, and the provider orientation kit.

To identify your assigned area rep, please click the following link: **Network Relations Consultant contact list**.

On the web...

Login to our provider portal, today!

Our free provider portal allows you to access critical information securely 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 advice
- And other helpful information

If you haven't yet registered, registering is easy:

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

Important formulary information

Visit **aetnabetterhealth.com/virginia/providers/pharmacy** for important formulary information such as:

- Medallion/FAMIS formulary and search tool
- 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 patient.

Latest provider manual

Our provider manual is reviewed annually, at a minimum, and is updated as needed. Your provider manual is your primary information source and an effective guide to your participation with us. It can be found on our website: **aetnabetterhealth.com/virginia/providers/manual**.

Cannabinoid oil and drug interactions

Cannabis plant
The cannabis plant has roughly 100 known cannabinoids, the two primaries being tetrahydrocannabinol (THC) and cannabidiol (CBD). THC is known for exerting psychoactive properties and is used as a measure of cannabis potency, unlike CBD, which does not carry psychoactive characteristics.

CBD oil
CBD oil is extracted from cannabis flowers or leaves (usually from the C.Sativa variation) and dissolved in an edible oil. CBD oil may vary from "hemp oil," which derives from the seeds of C.Sativa (low to no THC levels) and "cannabis oil," which carries the highest THC level and derives from the more potent C.indica plant. Terminology, however, has become interchangeable and differentiation based upon THC levels is opaque. CBD oil can be administered orally or sublingually with dosing dependent on indication and patient response.

Is CBD oil legal?
As of December 20, 2018, the Agriculture Improvement Act of 2018 has redefined the legality of certain cannabis products. Hemp, defined as cannabis (Cannabis sativa L.), was removed from the Controlled Substance Act along with cannabis derivatives with extremely low (less than 0.3% on a dry weight basis) THC content, deeming these substances now legal under federal law.

Drug interactions
The THC component of cannabis is primarily metabolized by the hepatic CYP-450 enzymes, CYP3A4 and CYP2C9, while CBD is metabolized by CYP3A4 and CYP2C19. Medications that process through these pathways have the potential to interact. Route of cannabis administration (i.e. inhaled versus oral) may affect extent of interaction.

Interaction Type*	THC	CBD
Major Metabolic Pathway (CYP-450)	CYP3A4 CYP2C9	CYP3A4 CYP2C19
Affected Metabolic Enzymes/Drug Transporters	Potential to inhibit CYP2C8, CYP2C9, and CYP2C19 May induce or inhibit CYP1A2 and CYP2B6 Inhibits UGT1A9 and UGT2B7	
Potential Drug Interactions (CYP-450 Substrates)	Anesthetics Angiotension II blockers Antiarrythmics Antibiotics Antidepressants Anti-epileptics Antihistamines Antipsychotics Benzodiazepines Beta blockers Calcium channel blockers HIV antivirals HMG CoA reductase inhibitors Immune modulators NSAIDs Oral hypoglycemic agents PPIs Sulfonylureas Steroids	
*List is not comprehensive of all of the potential medications impacted by cannabidiol nor will each medication necessarily cause an interaction.		

References

1. U.S. Food and Drug Administration. (2018). Statement from FDA Commissioner Scott Gottlieb, M.D., on signing of the Agriculture Improvement Act and the agency's regulation of products containing cannabis and cannabis-derived compounds. Retrieved from https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm628988.htm
2. Gorelick, David A. (2018). Cannabis Use and Disorder. Hermann R, ed. UpToDate. Retrieved from https://www.uptodate.com/contents/cannabis-use-and-disorder
3. Natural Medicines Comprehensive Database Consumer Version [Internet]. Stockton (CA): Therapeutic Research Faculty; ©1995-Cannabidiol. Clove; [reviewed 2018 Oct 29; cited 2019 Jan 2]; Available from: https://medlineplus.gov/druginfo/natural/1439.html
4. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2019. URL: http://www.clinicalpharmacology.com. Updated 8/2018.

Provider Advisory Committee

We invite our providers to join our provider advisory committee (PAC). Our committee meets monthly. The committee consists of providers who serve Medicaid, Medicare, and DSNP beneficiaries, other indigent populations, and members with special needs. We value your input. Your recommendations may be used to improve quality management activities and policy and operations changes. If you'd like to join, please email **Aetnabetterhealth-VAProviderRelations@aetna.com** with the subject line: Provider Advisory Committee.

Antidepressants and breastfeeding

Every year in the United States, there are approximately 500,000 pregnancies with concerns of psychiatric illness prior to or developed during pregnancy1. In addition, nearly 14% of women will develop postpartum depression in the first month after childbirth, resulting in a need for safe antidepressants for lactating women2.

Antidepressants that are safe to use during lactation The American College of Obstetrician and Gynecologist recommends Table 1 as a useful guide to determine lactation risks associated with commonly prescribed antidepressants.

Table 1. Safety of Antidepressant Medications During Lactation

Drug	Lactation Risk Category
Tricyclics and Heterocyclics	
Amitriptyline	L2
Amoxapine	L2
Clomipramine (Anafranil)	L2
Desipramine (Norpramin)	L2
Doxepin	L5
Imipramine (Tofranil)	L2
Maprotiline	L3
Nortriptyline (Pamelor)	L2
Protriptyline (Vivactil)	NA
Selective Serotonin Reuptake Inhibitors	
Citalopram (Celexa)	L3
Escitalopram (Lexapro)	L3 in older infants
Fluoxetine (Prozac)	L2 in older infants; L3 in neonates
Fluvoxamine	L2
Paroxetine (Paxil)	L2
Sertraline (Zoloft)	L2
Other Antidepressant	
Bupropion (Wellbutrin)	L3
Duloxetine (Cymbalta)	NA
Mirtazapine (Remeron)	L3
Nefazodone	L4
Trazodone	L2
Venlafaxine (Effexor)	L3

Lactation Risk Categories: L1 = safest; L2 = safer; L3 = moderately safe; L4 = possibly hazardous; L5 = contraindicated.

Antidepressants that decrease milk supply

- Monoamine oxidase inhibitors
  - Marplan (Isocarboxazid)
  - Nardil (Phenelzine)
  - Selegiline (Zelapar)
  - Tranylcypromine (Parnate)
- Antidepressants with anticholinergic properties
  - Paroxetine (Paxil) is the most anticholinergic SSRI
  - All TCAs have anticholinergic properties

How to select an antidepressant

- Women successfully treated with an antidepressant prior to lactation generally should not change medications during lactation.
- SSRI are first-line agents for treating moderate to severe depression.
  - Sertraline or Paroxetine are preferred due to low RID.
  - Start with lowest effective dose and increase slowly.
- Monotherapy is preferred.
- To minimize the effects of antidepressant during lactation.
  - Select agent with a short half-life.
  - Administer at bedtime or after infant is done feeding.

How to monitor

- **Infant**
  - Conduct pediatric assessment at baseline, consider age and health status of infant.
  - Monitor neurodevelopment and growth (poor weight gain).
  - Monitor daily for changes in sleep, feeding patterns and behavior (constant crying, lethargy, restlessness, irritability, or agitation).

- **Mother**
  - Assess at baseline.
  - Monitor for delayed lactogenesis if antidepressant started during pregnancy.
  - Monitor for decreased milk supply if antidepressant started after milk supply is already established.
  - It's important that the mother informs the child's pediatrician of the antidepressant.

References

1. Clinical Management Guidelines for Obstetrician-Gynecologists Use of Psychiatric Medications During Pregnancy and Lactation. (2009). Focus, 7(3), 385-400. doi:10.1176/foc.7.3.foc385
2. Kim, D. R., Epperson, C. N., Weiss, A. R., & Wisner, K. L. (2014). Pharmacotherapy of postpartum depression: An update. Expert Opinion on Pharmacotherapy, 15(9), 1223-1234. doi:10.1517/14656566.2014.911842
3. Psychiatric Disorders During Pregnancy. (n.d.). Retrieved from, https://womensmentalhealth.org/specialty-clinics/psychiatric-disorders-during-pregnancy/
4. Berle, J. O., & Spigset, O. (2011). Antidepressant Use During Breastfeeding. Current Women's Health Reviews, 7(1), 28-34. doi:10.2174/157340411794474784

HIV and PrEP

What is Pre-Exposure Prophylaxis?
Pre-exposure prophylaxis, or PrEP, is a way for HIV-negative individuals, who are at high risk of contracting the virus, to prevent infection by taking a daily HIV medication. Once daily oral treatment with Truvada is the only FDA-approved medication for PrEP. When taken as prescribed, Truvada reduces the risk of HIV from sex by more than 90% and from injectable drug use by more than 70%, according to the CDC.

The United States Preventative Services Task Force (USPSTF) supports that PrEP is of substantial benefit in decreasing the risk of HIV, and that adherence is highly correlated with efficacy of treatment.

PrEP is not an alternative to safe sex practices
Condoms are included on the Medicaid formulary at no cost for members. When used correctly, condoms reduce the risk of HIV acquisition by approximately 80%. The CDC recommends providing prescriptions for condoms along with risk reduction counseling at every office visit.

Additionally, HIV medications do not protect against other STDs and individuals are 3 times more likely to get or transmit HIV if they have a concurrent STD. The CDC and USPSTF promote consistent condom use as an important component of a successful PrEP program.

Along with condom use and intensive risk counseling, additional prevention techniques include abstinence, mutual monogamy, reducing the number of sexual partners, needle exchange programs, and post-exposure prophylaxis after a potential exposure event.

Quick Facts
- Once daily Truvada for PrEP is an effective way to prevent HIV in high risk members when taken every day.
- PrEP does not protect against other STDs and should supplement, rather than replace safe sex practices.
- Condoms are included on the Medicaid formulary at no cost for members

Summary of Guidance for PrEP Use

	Men who have sex with men	Heterosexual women and men	Injection drug users
Detecting substantial risk of acquiring HIV infection:	• Sexual partner with HIV • Recent bacterial STD • High number of sex partners • History of inconsistent or no condom use • Commercial sex work	• Sexual partner with HIV • Recent bacterial STD • High number of sex partners • History of inconsistent or no condom use • Commercial sex work • Lives in high-prevalence area or network	• HIV-positive injecting partner • Sharing injection equipment • Recent drug treatment (but currently injecting)
Clinically eligible:	• Documented negative HIV test before prescribing PrEP • No signs/symptoms of acute HIV infection • Normal renal function, no contradicted medications • Documented hepatitis B virus infection and vaccination status		
Prescription	Daily continuing oral doses of TDF/FTC (Truvada), ≤ 90-day supply		
Other services:	• Follow-up visits at least every three months to provide: • HIV test, medication adherence counseling, behavioral risk reduction support, side effect assessment, STD symptom assessment • At three months and every six months after, assess renal function • Every six months, test for bacterial STDs		
	Do oral/rectal STD testing	Assess pregnancy intent and give pregnancy test every three months	Access to clean needles/ syringes, as well as drug treatment services

Source: CDC resource for providers, Fact Sheet: Pre-Exposure Prophylaxis for HIV Prevention

References
1. Pre-exposure Prophylaxis for the Prevention of HIV Infection in the United States A Clinical Practice Guideline. CDC. Retrieved from https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf
2. Prevention of Human Immunodeficiency Virus (HIV) Infection: Pre-Exposure Prophylaxis Draft Recommendation Statement. USPSTF. Retrieved from https://www.uspreventiveservicestaskforce.org/Page/Document/draft-recommendation-statement/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis
3. Pre-Exposure Prophylaxis (PrEP). CDC. Retrieved from https://www.cdc.gov/hiv/risk/prep/index.html
4. Fact Sheet: Pre-Exposure Prophylaxis (PrEP) for HIV Prevention. CDC. Retrieved from https://www.cdc.gov/hiv/pdf/PrEP_fact_sheet_final.pdf

Remember: 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).

Medicaid Expansion Eligibility Verification

Medicaid coverage for the new adult group began January 1, 2019. Providers may use the Virginia Medicaid Web Portal and the Medicall audio response systems to verify Medicaid eligibility and managed care enrollment, including for the new adult group. In the Virginia Medicaid Web Portal, individuals eligible in the Medicaid expansion covered group will be shown as "MEDICAID EXP." If the individual is enrolled in managed care, the "MEDICAID EXP" segment will be shown as well as the "MED4" (Medallion 4.0) or "CCCP" (CCC Plus) managed care enrollment segment. Additional Medicaid expansion resources for providers are available on the DMAS Medicaid Expansion webpage at **http://www.dmas.virginia.gov/#/medex**.

Spotlight on Dual Special Needs Plan (DSNP)

Don't let your network status change — complete your FDR attestation today

If you are a participating provider in our Dual Special Needs Plan (DSNP), you must meet the CMS compliance program requirements for first-tier, downstream and related (FDR) entities. You also must confirm your compliance through an annual attestation.

How to complete your attestation
You'll find the resources you need to ensure your compliance on the Medicare Compliance Attestation page of the Aetna Better Health of Virginia website:

1. Go to **www.aetna.com**
2. Select **Providers**
3. Select **Products & Programs**
4. Select Medicare

On the right side of the screen are links about completing education for the FDR. Once you've made sure you've met the requirements, simply select the link on the **Medicare Compliance Attestation** page that corresponds to your contracting status. One annual attestation meets all your Aetna Better Health of Virginia compliance obligations.

Learn more about our HMO SNP plan

Interested providers and offices are encouraged to call 1-855-463-0933 or send an email to VADSNPSALESTEAM@aetna.com to request a call back or an office visit.

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 A and B and who receive Medicaid assistance from the Commonwealth Coordinated Care Plus (Medicaid) and do not have end stage renal disease. Additionally, please visit us on the web at **aetnabetterhealth.com/virginia-hmosnp**.

Spotlight on Quality

Our Care Management Program

Members with complex healthcare needs often need extra help understanding their choices and benefits. They need support navigating the community resources and services available. Our Integrated Case Management Program is a collaborative process that involves the member, their caregivers, their providers and a nurse care manager.

We aim to efficiently manage our members' healthcare while producing better health outcomes. Please call us at **1-800-279-1878** to refer your patients to our Integrated Case Management Program.

Chronic conditions

Does your Aetna Better Health of Virginia patient have a chronic condition? These include:

- Diabetes
- Coronary artery disease
- Asthma
- Depression
- COPD
- Congestive heart failure

We can help! Education and self-management are important aspects to managing these chronic conditions. Our members who identify with one or more of these diagnoses will receive educational mailings. In addition, high-risk member will receive an outreach call from our trained staff. A face-to-face visit may be completed to further the member's understanding of managing their chronic illness.

We utilize a biopsychosocial model to encompass all aspects of a member's care. We will assist in support coordination, social barrier solutions, community resource access, benefit navigation and any other referrals the member may need.

If your patient has one of the above chronic conditions, you can call Member Services at **1-800-279-1878**, Monday through Friday, 8 a.m. to 5 p.m.

Utilization Management (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

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

Need help? Visit our website
Go to **aetnabetter health.com/virginia**. From the home page, select **For Providers**, then select each section to learn about:

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

Continuity of Care Reminder: Emergency Room Visits

We would like to remind practitioners and providers about the importance of communication regarding members who have had Emergency Room visits:

- Facilities should obtain PCP information and transmit ER visit discharge summaries, including the physician's documentation.
- PCPs should obtain ER visit discharge summaries

and file them in member medical records.
- If using electronic medical records, PCPs should note in member medical records indicating that ER visit discharge summaries have been reviewed and a brief summary should be documented.

Help improve communication between treating providers

PCPs are concerned because they're not getting regular reports about their patients' care from other treating providers. That's according to a recent survey we did assessing our interaction with primary care practices. This lack of communication can pose a threat to patient care. Coordinating care with various physicians, facilities and behavioral health care professionals can be a challenge. And we appreciate your efforts to improve communication.

To help ensure comprehensive care, it's critical that PCPs and specialists talk openly with each other.

Five ways to improve your ADD HEDIS® follow-up scores

What is the HEDIS measure?

The HEDIS measure is the percentage of children, ages 6 to 12 years old, who have had a new prescription for an ADD medication dispensed and have had at least:

- One follow-up visit within 30 days of medication dispensed with a practitioner who has prescribing authority (initiation phase).
- Two follow-up visits within 270 days (9 months) after the end of the initiation phase (continuation and maintenance phase).

Best practices for improving your ADD HEDIS scores

1. When the initial prescription is written, schedule the follow-up visit to occur within 14 to 21 days. This is needed to assess how the medication is working. Schedule the follow-up visit before your patient leaves the office.
2. The initial follow-up visit occurs before a refill is given.
3. After the first 30 days, continue to monitor your patient's progress. Schedule your patient for two more visits over the next nine months. You may need to see your patient more often as you adjust the medication.
4. If the member cancels an appointment, please reschedule immediately.
5. During your patients visit, encourage parents and caregivers to ask questions about their child's ADD, such as how to care for the condition and why it is important to adhere to your instructions.

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!

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.