December 2024

OfficeLink Updates™

Welcome to the latest edition of OfficeLink Updates (OLU). As always, we provide you with relevant news for your office.

HIGHLIGHTS IN THIS ISSUE

New credentialing requirement for Individual Nurse Practitioners

New practitioners will need to go through the provider onboarding process and complete a CAQH application.

Now available: a clinical questionnaire to request skilled nursing facility (SNF) stays

As with our other clinical questionnaires, you can complete the SNF clinical questionnaire on Availity. A hospital or the SNF can request a stay. Refer to the Resources section of Availity for tips.

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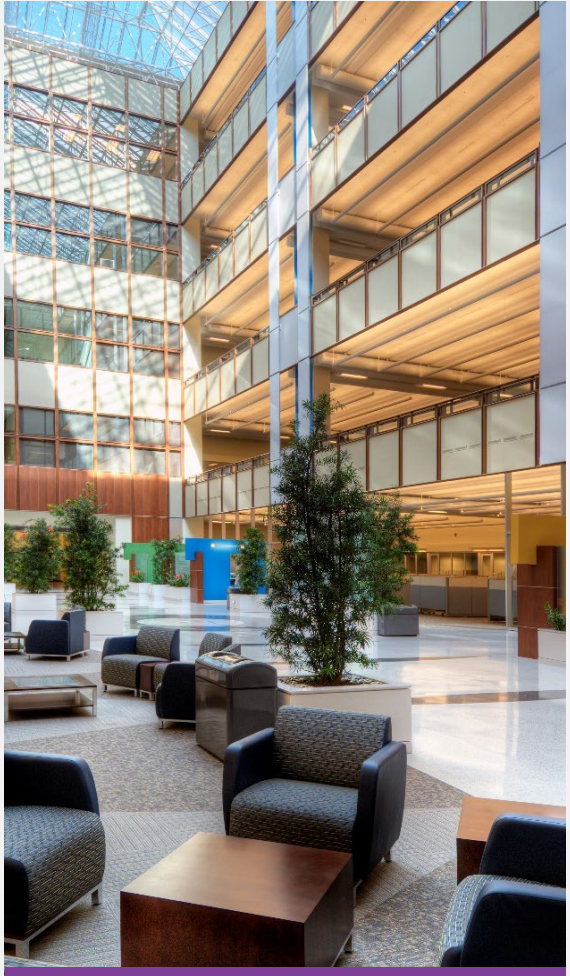

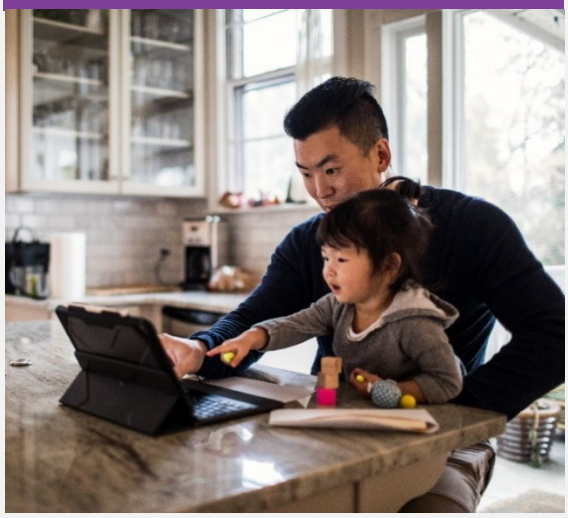

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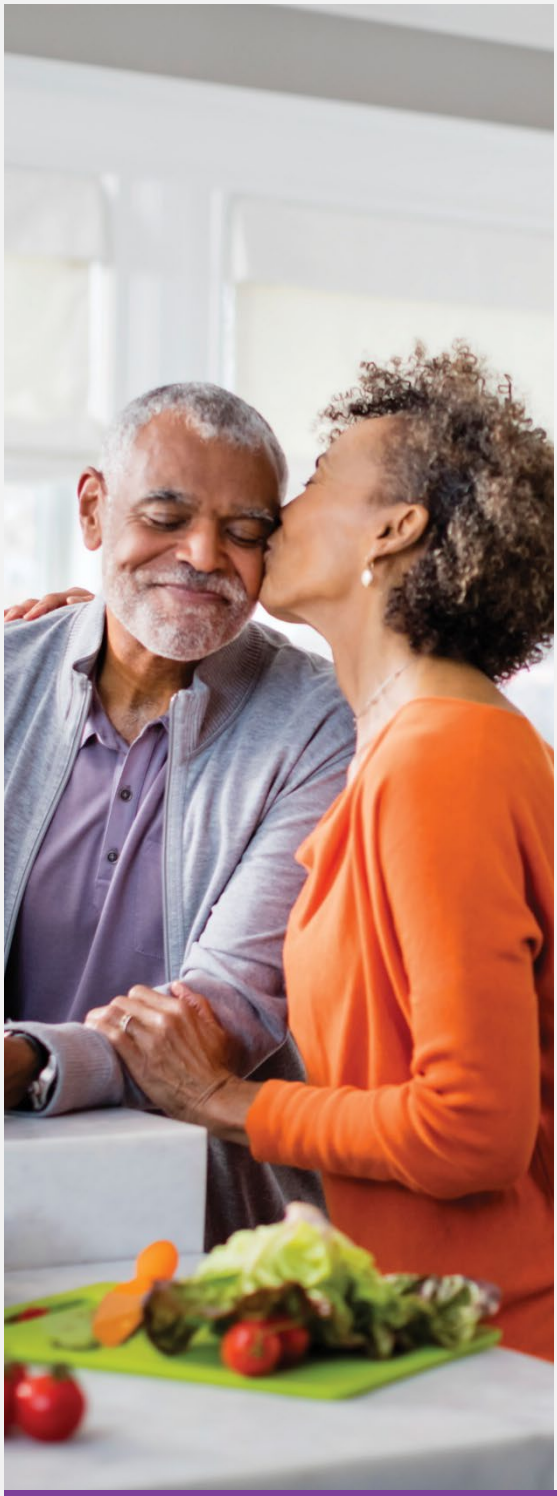

90-day notices and related reminders

We regularly adjust our clinical, payment and coding policy positions as part of our ongoing policy review processes. Our standard payment policies identify services that may be incidental to other services and, therefore, ineligible for payment.

We're required to notify you of any change that could affect you either financially or administratively at least 90 days before the effective date of the change. These changes may not be considered material changes in all states.

Unless otherwise stated, policy changes apply to both Commercial and Medicare lines of business.

Claim and Code Review Program (CCRP) update

We might have new claim edits for our commercial, Medicare and Student Health members. You can view them on Availity®.

This update applies to our commercial, Medicare and Student Health members.

Beginning March 1, 2025, you may see new claim edits. These are part of our CCRP. These edits support our continuing effort to process claims accurately for our commercial, Medicare and Student Health members. You can view these edits on our **provider portal on Availity**.*

For coding changes, go to Aetna Payer Space > Resources > Expanded Claim Edits.

Except for Student Health, you'll also have access to our code edit lookup tools. To find out if our new claim edits will apply to your claim, log in to our **provider portal on Availity**. You'll need to know your Aetna® provider ID number (PIN) to access our code edit lookup tools.

We may request medical records for certain claims, such as high-dollar claims, implant claims, anesthesia claims, and bundled services claims, to help confirm coding accuracy.

*Availity is available only to providers in the U.S. and its territories.

Note to Washington providers: For commercial plans, your effective date for changes described in this article will be communicated to you following regulatory review.

Note to Texas providers: Changes described in this article will be implemented for fully insured plans written in the state of Texas only if such changes are in accordance with applicable regulatory requirements. Changes for all other plans will be as outlined in this article.

Note to Maine and Vermont providers: For commercial plans, your effective date for routine changes described in this article will be the statutory date of January 1, April 1, July 1 or October 1, whichever date follows the effective date(s) referred to in this article. Changes required by state or federal law, or pursuant to revisions of Current Procedural Terminology (CPT®) codes published by the American Medical Association, may be effective outside the statutory dates outlined above.

Changes to commercial drug lists begin on April 1

Find out about drug list changes and how to request drug prior authorizations.

On April 1, 2025, we'll update our pharmacy drug lists. Changes may affect all drug lists, precertification, step therapy and quantity limit programs.

You'll be able to view the changes as early as February 1, 2025. They'll be on our **Formularies and Pharmacy Clinical Policy Bulletins** page.

Ways to request a drug prior authorization

- Submit your completed request form through our **provider portal on Availity**.*
- For requests for non-specialty drugs, call **1-800-294-5979 (TTY: 711)**. Or fax your **authorization request form (PDF)** to **1-888-836-0730**.
- For requests for drugs on the Aetna Specialty Drug List, call **1-866-814-5506 (TTY: 711)** or go to our **Forms for Health Care Professionals** page and scroll down to the Specialty Pharmacy Precertification (Commercial) drop-down menu. If the specific form you need is not there, scroll to the end of the list and use the generic Specialty Medication Precertification request form. Once you fill out the relevant form, fax it to **1-866-249-6155**.

Medications on the Aetna Drug Guide, precertification, step-therapy and quantity limits lists are subject to change.

More information

For more information, refer to the **Contact Aetna** page. Select the Providers tab. In the "Call us" column, choose "Special programs" from the drop-down menu and use the "Pharmacy management" number.

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Important pharmacy updates

Read the updates for Medicare, Medicare Part B step therapy and commercial.

Medicare

Visit our **Medicare drug list** page to view the most current Medicare plan formularies (drug lists). We update these formulary documents regularly during the benefits year as we add or update additional coverage each month.

Visit our **Medicare Part B step therapy** page to view the most current Preferred Drug Lists for Medicare Advantage (MA) and Medicare Advantage with prescription drug coverage (MAPD) members. We update these lists regularly throughout the plan year.

Commercial — notice of changes to prior authorization requirements

Visit our **Formularies and Pharmacy Clinical Policy Bulletins** page to view:

- Commercial pharmacy plan drug guides with new-to-market drugs we add monthly
- Clinical policy bulletins with the most current prior authorization requirements for each drug

Student Health

Visit **Aetna Student Health** to view the most current Aetna Student Health℠ plan formularies (drug lists). Follow these steps:

1. Select your college or university and click “View your school.”
2. Select the “Members” link at the top of the page.
3. Click the “Prescriptions” link under Resources for Members.
4. Scroll down to the Aetna Pharmacy Documents section.

Aetna federal employee plans

Visit our **Aetna Federal Plans** website to view the most current formularies (drug lists).

State-specific updates

Here you'll find state-specific updates on programs, products, services, policies and regulations.

Aetna® to expand coverage within the individual exchange market in eight states

We have new service areas for the Aetna CVS Health® ACA plan. Check to see if you participate.

Note: This article applies to the following states: Florida, Illinois, Indiana, Kansas, Missouri, North Carolina, Ohio and Texas.

We're expanding! Florida, Illinois, Indiana, Kansas, Missouri, North Carolina, Ohio and Texas will see expanded service areas for the Aetna CVS Health® Affordable Care Act (ACA) insurance product (subject to regulatory approval) on the individual exchange market starting January 1, 2025. Look for "QHP" (qualified health plan) on member ID cards.

Today, our ACA exchange membership has access to our provider networks in Arizona, California, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Maryland, Missouri, Nevada, New Jersey, North Carolina, Ohio, Texas, Utah and Virginia.

Welcome our new members by checking your participation status

- If you practice in California, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Maryland, Missouri, Nevada, New Jersey, North Carolina, Ohio, Texas or Utah, go to the **Aetna CVS Health provider directory** to check your status.
- If you practice in Arizona, go to the **Banner Aetna directory** to check your participation status in the Banner|Aetna Performance Network.
- If you are an Aetna provider in Virginia, go to the **Aetna CVS Health provider directory** to check your status. If you are an Innovation Health provider in Northern Virginia, you can check the **Innovation Health provider directory**.

Questions?

If you have questions, please **refer to our FAQs** or visit the **Contact Aetna** page. In the "Call us" column, choose "Aetna service centers" and use the "non-Medicare plans" number.

Aetna®, CVS Pharmacy®, and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic®-branded walk-in clinics), are part of the CVS Health® family of companies.

Appointment wait-time requirements

CMS requires us to complete secret shopper surveys.

This article applies to the following states: Arizona, Delaware, Florida, Illinois, Indiana, Kansas, Missouri, Nevada, North Carolina, Ohio, Texas, Utah and Virginia.

What are the surveys about?

The Centers for Medicare & Medicaid Services (CMS) requires all medical qualified health plan (QHP) issuers offering QHPs in the Federally-facilitated Exchanges (FFEs) to administer secret shopper surveys with primary care and behavioral health providers to confirm compliance with wait-time standards.

For the 2025 plan year, QHP issuers will be required to ensure that enrollees seeking an appointment are able to schedule an appointment within the time frames below at least 90% of the time. CMS is particularly concerned with the ability of new patients to schedule appointments with in-network providers.

Provider specialty type	Appointments must be available within
Behavioral health	10 business days
Routine primary care	15 business days
Specialty care (non-urgent)	30 business days

When do the surveys occur?

Surveys begin on or shortly after January 1 and end by May 31 of each plan year.

Remember, you are required to comply with the Aetna® participation requirements included in our **provider manuals**.

Watch for the new Aetna® Medicare Extra Benefits Card

Aetna members will have a new card in 2025.

This article applies to Illinois, Indiana, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, Ohio and Wisconsin.

Starting in 2025, Aetna Medicare members enrolled in certain plans could have access to our Medical Expense Wallet, which holds a quarterly benefit allowance accessible via the Aetna Medicare Extra Benefits Card.

Members can present this card at the time of appointment to cover copays associated with services such as physician visits, lab work, and vision and hearing exams.

Members can check their balance by visiting **CVS.com/Aetna** or by calling CVS Health® at **1-844-428-8147 (TTY: 711)**, 8 AM–8 PM local time, 7 days a week.

Changes to the Aetna® Medicare Advantage (MA) home health program (Carelon) start on January 1, 2025

Carelon will no longer manage credentialing, utilization management or claims payment for home health care providers and services.

This article applies to Connecticut, Pennsylvania and West Virginia.

As of January 1, 2025, the Carelon Home Health Program will end for MA members in the states of Connecticut, Pennsylvania, and West Virginia, and Carelon will no longer manage credentialing, utilization management or claims payment for home health care providers and services.

Contract changes

When the Carelon program ends in Connecticut, Pennsylvania, and West Virginia, you will continue to participate in the Aetna networks if you already have a direct contract on file with Aetna. If you don't, you will need to submit a request to the National Ancillary Team at **NationalAncillaryContracting@Aetna.com**.

Claims payment changes

As of January 1, 2025, don't submit home health care claims for Aetna MA members in Connecticut, Pennsylvania and West Virginia to Carelon. You should submit these types of claims directly to Aetna.

Precertification changes

Starting January 1, 2025, home health care services for Aetna MA members in Connecticut, Pennsylvania and West Virginia no longer require precertification.

Questions?

If you have questions, please contact Aetna Medicare at **1-855-335-1407 (TTY: 711)** and choose option 4.

Illinois and Pennsylvania: We will require Verification of Chronic Condition (VCC) forms for C-SNP enrollees starting January 1

You must submit the VCC form within 30 days of member enrollment in a C-SNP.

Beginning January 1, 2025, Aetna® will offer Chronic Special Needs Plans (C-SNPs), a type of Medicare Advantage (MA) plan, in select counties in Illinois and Pennsylvania. These plans aim to help members with diabetes and/or heart disease better manage their chronic conditions and improve their overall health.

The Centers for Medicare & Medicaid Services (CMS) requires providers to verify that the member has an eligible condition.

C-SNP enrollment is a two-step process

Step 1: Enrollees complete a Medicare Pre-Qualification Assessment Tool (PQAT) form.

> Enrollees *must* complete a PQAT form showing their qualifying diagnosis and their provider's contact information.

Step 2: Providers complete the VCC form within the first 30 days of enrollment.

> We will send a VCC form to you for completion within the first 30 days of the member's enrollment. If we don't receive it, we will disenroll the member at the end of the second month enrolled.

Please complete the VCC form as quickly as possible after you receive it.

Need a copy of the form?

Access the **VCC form (PDF)** on:

- **Availity**
- **Aetna.com** (choose "Working with us," then "Forms")

Fax the completed form to our Enrollment Department at **1-866-756-5514** or send via secure email to **VCC@Aetna.com**.

Illinois: Help us comply with a law about how we communicate contractual changes

We need to collect and store a current email address for you or an authorized staff member.

Illinois law requires insurers and HMOs to email you about nonroutine changes to contractual fee schedules as outlined in a newsletter, website listing or other method.

As a result, we need to collect and store a current email address for you or a staff member who is authorized to receive this information.

How to give us a current email address

If you use Availity,* follow these steps:

1. **Log in to Availity**.
2. Go to My Providers > Provider Data Management (user must have access and be listed as Key Staff by their office Availity Administrator).
3. Select Business/Provider to update > select Key Staff name.
4. Complete the Key Staff information, including email address.
5. Choose Save.

We appreciate your help

Thank you for giving us an email address. If you have any questions about how to provide or update your email address or if you would like more information on why we need it, visit our **Contact Aetna** page to find out how to reach us.

*Availity is available only to providers in the U.S. and its territories.

Maryland: Individual and Family Plan (IFP) member language patterns

Know the languages your patients speak and how to secure translation services.

Aetna® offers IFPs in all Maryland counties. We are committed to reducing health disparities in all communities and improving the health of our IFP members.

We have collected data on the prevalent languages of our IFP membership, and we believe that sharing this information with you will help improve the quality of the patient-provider

relationship and mitigate language barriers. The table below shows the top non-English languages that our IFP members speak in the state of Maryland.

Maryland IFP member language patterns	
Language	**Percentage**
English	64.12%
Spanish	4.95%
Russian	0.11%
Portuguese	0.04%
French	0.14%
Vietnamese	0.18%
Not provided	30.47%

Note: Column percentages may not add up to 100% due to rounding.

The language assistance requirement

As a contracted provider, you are required to provide language assistance at the time of the appointment. Please call the dedicated toll-free telephone number to access interpretation services. There is no charge for these services. You can call **1-855-380-5345 (TTY: 711)** to reach a qualified interpreter directly.

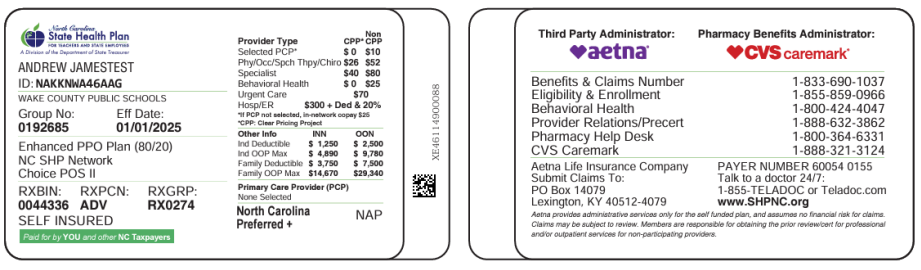
North Carolina (NC) State Health Plan goes live January 1, 2025

Aetna® will be the new third-party administrator for the NC State Health Plan beginning January 1, 2025.

New member ID cards with unique ID numbers

NC State Health Plan members will have unique ID cards. ID numbers will start with “N” and be followed by either 11 letters or 11 alphanumeric characters (for example, NABCDEFGHI6P).

Here’s what the card looks like:



Stay up to date on the latest NC State Health Plan news

Visit the **NC State Health Plan** page for important information and updates.

Ohio and Pennsylvania: On January 1, 2025, CMS will end the Hospice Benefit Component of the Value-Based Insurance Design (VBID) model

Certain Medicare Advantage (MA) benefits for hospice members meeting CCT program criteria will end on January 1, 2025.

Note: This article applies to Ohio and Pennsylvania.

Aetna® participated in the Centers for Medicare & Medicaid Services (CMS) Hospice VBID model by offering the Aetna Compassionate Care℠ Transitions Program (CCT) in select Medicare Advantage (MA) plans in Ohio and Pennsylvania. The program, which gave additional MA benefits to hospice members meeting CCT program criteria, will end on January 1, 2025. This change will not impact other benefits of the member's core Aetna MA plan.

What can MA hospice members expect?

The Aetna care management team will assist and support MA CCT members who are transitioning from Aetna MA to Original Medicare for hospice care.

Next steps for you

- Submit hospice claims for MA CCT members to Aetna with dates of services through December 31, 2024.
- Submit hospice claims and all notices (election, termination and revocation) for dates of services in 2024 to both Aetna and your Medicare Administrative Contact (MAC).
- On January 1, 2025, submit hospice claims to your MAC, as coverage will transition to Medicare Part A.

We're here to help

How to reach us:

- For hospice CCT questions, claim submissions, or other issues, contact Nichole Riston, Aetna Provider Services Department, at **HospiceVBIDInquiries@Aetna.com**.
- Contact CCT care management at **MedicareCMDirectReferrals@Aetna.com** or call **1-833-433-1197** (TTY: **711**).
- Preferred CCT providers may continue using the Teams site through December 31, 2024. It will no longer be available on January 1, 2025.

Thank you for your dedication to promoting quality compassionate care to our Aetna MA members.

Pennsylvania and Illinois: We will require Verification of Chronic Condition (VCC) forms for C-SNP enrollees starting January 1

You must submit the VCC form within 30 days of member enrollment in a C-SNP.

Beginning January 1, 2025, Aetna® will offer Chronic Special Needs Plans (C-SNPs), a type of Medicare Advantage (MA) plan, in select counties in Illinois and Pennsylvania. These plans aim to help members with diabetes and/or heart disease better manage their chronic conditions and improve their overall health.

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- On January 1, 2025, submit hospice claims to your MAC, as coverage will transition to Medicare Part A.

We're here to help

How to reach us:

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Pennsylvania: changes to the Aetna® Medicare Advantage (MA) home health program (Carelon) start on January 1, 2025

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This article applies to Connecticut, Pennsylvania and West Virginia.

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Contract changes

When the Carelon program ends in Connecticut, Pennsylvania, and West Virginia, you will continue to participate in the Aetna networks if you already have a direct contract on file with Aetna. If you don't, you will need to submit a request to the **National Ancillary Team**.

Claims payment changes

As of January 1, 2025, don't submit home health care claims for Aetna MA members in Connecticut, Pennsylvania and West Virginia to Carelon. You should submit these types of claims directly to Aetna.

Precertification changes

Starting January 1, 2025, home health care services for Aetna MA members in Connecticut, Pennsylvania and West Virginia no longer require precertification.

Questions?

If you have questions, please contact Aetna Medicare at **1-855-335-1407 (TTY: 711)** and choose option 4.

Texas: The Aetna Smart Compare™ program for fully insured membership arrives in 2028

The Aetna Smart Compare program

Aetna Smart Compare is a provider designation program that evaluates our participating providers, identifying those that meet higher standards of quality and cost-effectiveness.

The national program began in 2021 and has continued to expand by specialty. Self-insured plans have had access to this program since then, and that access will continue.

Expansion to fully insured plans in 2028

Texas members on fully insured plans will gain access to Aetna Smart Compare physician designations in the 2028 program. Once the designations are available, members and prospective members can access information about a physician's designation when they search for a provider in their Aetna® accounts, call our support lines or access our public provider directory.

Evaluation notification

In late 2024, we will notify the physicians we will evaluate. These physicians can go to our **Aetna Smart Compare Designation** page and refer to the Aetna Smart Compare Methodology Guide to access the latest standards and measurements applicable during the evaluation period. The guide will also list the specialties that will be part of the 2028 program.

When you will be evaluated

We will evaluate physicians in 2027, using claims data from 2025 and 2026.

How to know if you've received a designation

Every year in the fourth quarter, we will communicate the designation to applicable physicians. For the 2028 program, we will communicate this in the fourth quarter of 2027.

How to dispute a designation

Physicians will have an opportunity to dispute the designation before it is published through a process that includes the following protections:

- We will provide at least 45 days' written notice of the designation, including the methodologies, data and all other information we used to arrive at the designation.
- Physicians can request a fair reconsideration proceeding within 30 days of receiving the written notice. Fair reconsideration proceedings will be conducted in accordance with Texas Insurance Code 1460.003(B)-(D).
- All reconsiderations, even those that extend past 45 days from our original notice, may lead to our reversing our decision for your practice, regardless of the length of our exchange.

West Virginia: Changes to the Aetna® Medicare Advantage (MA) home health program (Carelon) start on January 1, 2025

Carelon will no longer manage credentialing, utilization management or claims payment for home health care providers and services.

This article applies to Connecticut, Pennsylvania and West Virginia.

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Questions?

If you have questions, please contact Aetna Medicare at **1-855-335-1407** **(TTY: 711)** and choose option 4.

West Virginia: Reimbursement for emergency medical services

This article applies to fully insured commercial business.

Effective January 1, 2025, emergency medical services (EMS) providers can seek reimbursement for triage, treating and transporting a member to an emergency room or other location. The rate of reimbursement is the same regardless of where the member is

transported. Note that if the member is not transported at all, EMS providers may still seek reimbursement, but the reason for not transporting must be one of the following:

- The member declines to be transported even against medical advice.
- The provider is coordinating the member's care via telehealth services or medical command.
- The provider is coordinating behavioral-health-related care for a behavioral-health-based complaint.

For more information, read the **statute governing this update**.

News for you

You'll find information — new services, tools and reminders — to help your office comply with regulations and administer plans.

New credentialing requirement for Individual Nurse Practitioners

Last October 15, Aetna® started credentialing all Individual Nurse Practitioners except those who are hospital-based or delegated. Aetna initiated this new requirement in accordance with changing industry practices.

Note the following:

- New Individual Nurse Practitioners will need to go through the **provider onboarding** process. They will need a complete Council for Affordable Quality Healthcare (CAQH) application to begin the credentialing process.
- We will add existing non-credentialed Individual Nurse Practitioners into a credentialing cycle over the coming months. The process will be quick if practitioners already have a complete CAQH application.

Training webinar update

We recently evaluated on-demand and live training options hosted by Availity®.

We are pleased to tell you that the topics we typically cover in a few of our live webinars are included in demos that Availity offers.* Therefore, we will no longer offer certain webinars. Check out the following courses, which you can find in the Help and Training section of Availity.

- Provider Data Management and Directory Verification – non-payer specific (24 minutes)
- Eligibility and Benefits Inquiry — non-payer specific (25 minutes)
- Patient Cost Estimator — non-payer specific (5 minutes)
- Professional Claim — non-payer specific (15 minutes)
- Facility Claim — non-payer specific (8 minutes)
- Availity Claim Status — non-payer specific (10 minutes)
- Availity Appeals — non-payer specific (9 minutes)
- Referral Submission Training — non-payer specific (5 minutes)
- Auth/Referral Inquiry — non-payer specific (5 minutes)
- Fee Schedules — non-payer specific (3 minutes)

You can also find refreshed, Aetna-specific resource guides in Availity > Aetna Payer Spaces > Resources.

*Availity is available only to providers in the U.S. and its territories.

Take accredited health equity courses to better serve your patients

Help meet the cultural and linguistic needs of your diverse patients.

Health equity means that everyone has a fair and just opportunity to achieve optimal health. A culture of learning and engagement is key to advancing health equity goals.

The **Think Cultural Health website**, sponsored by the Office of Minority Health (OMH), offers a free online educational program accredited for physicians, physician assistants and nurse practitioners. It's called **A Physician's Practical Guide to Culturally Competent Care**, and it's intended to furnish the knowledge, skills and awareness to best serve all patients, regardless of their cultural or linguistic background.

There are three courses in the program:

- Course 1 covers the fundamentals of **Culturally and Linguistically Appropriate Services (CLAS)**, including strategies for delivering patient-centered care.
- Course 2 covers communication and language assistance, including how to work effectively with an interpreter.
- Course 3 covers organizational CLAS-related activities, including strategic planning and community assessment.

What is CLAS?

CLAS advances health equity, improves quality and helps eliminate health care disparities by establishing a blueprint for health and health care organizations to provide effective,

equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Please take advantage of the free courses. We are happy to help you meet the cultural and linguistic needs of our members.

How to meet the linguistic needs of our members

Use our dedicated phone number for translation services.

Aetna® is committed to providing equitable, high-quality health care. To help reduce health disparities and promote health equity, we collect member language preferences. Preferred languages are not currently visible in Availity®.*

At clinical points of contact, Aetna CVS Health® providers (for example, physicians, ancillary providers, dentists, behavioral health practitioners and all facilities) may call a dedicated 24/7 toll-free telephone number, **1-855-380-5345 (TTY: 711)**, to access interpretation services for their Aetna CVS Health® members at no cost to the member or provider. This telephone number bypasses the Provider Contact Center and links you directly to qualified interpreters at the Language Line.**

*Availity® is available only to providers in the U.S. and its territories.

**Aetna CVS Health® has not delegated any language assistance functions to its contracted provider.

Cultural competency can help your practice

You can improve your relationship with your patients by taking simple steps, such as directing patients to interpretation services and registering for Continuing Medical Education (CME) courses.

Recognizing that members have diverse views is critical to meeting their needs. The cultural factors that will likely affect your relationships with members include age, gender identity, language, religion, and values, to name a few. It's important to respect and respond to members' distinct values, beliefs, behaviors and needs when caring for them.

Our commitment

We're committed to meeting the National Committee for Quality Assurance (NCQA) standards to ensure that we meet members' cultural, ethnic, racial and language needs.

Culture, race and ethnicity

To demonstrate our commitment to meeting all NCQA standards and ensuring that member access to care is available and satisfactory, each year we ask members about in-network providers' ability to meet their needs. We do this through the Consumer Assessment of Healthcare Providers and Systems (CAHPS). We use the responses to monitor, track and improve members' experiences.

Language

Members with limited English proficiency have access to translation and interpretation services. Members also have access to TTY/TDD services for the hearing impaired.

Your Aetna® patients can access interpreter services by calling the number on the back of their ID card. There is no charge for this interpretation service.

Practitioner training on cultural competency, humility, diversity and inclusion:

- Visit our new **clinical educational hub**. It includes free, on demand courses on health equity and related topics.
- The U.S. Department of Health & Human Services, Office of Minority Health, offers free, **continuing education e-learning programs** (Culturally and Linguistically Appropriate Services in Maternal Health Care, Behavioral Health, Oral Health) to help health care professionals provide culturally competent care.
- The American Medical Association **Delivering Care — Health Equity** and the American Academy of Family Physicians **Health Equity CME** websites offer resources and educational opportunities, including CME courses, for additional training on multiple topics, including health equity, diversity and inclusion.
- Visit our **Health Equity page** to find out more about reducing health care disparities.

Want to learn more?

Watch our **cultural competency training video**.

Our office manual keeps you informed

Refer to this manual for information about policies, utilization management decisions and medical record documentation.

Visit us online to view a copy of your **Office Manual for Health Care Professionals (PDF)**. The Aetna® office manual applies to the following joint ventures: Allina Health | Aetna, Banner|Aetna, and Texas Health Aetna.

If you don't have Internet access, call our Provider Contact Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)** to get a paper copy.

What's in the manual

The manual contains information on the following:

- Policies and procedures
- Our complex case management program and how to refer members
- Additional health management programs, including disease management, the Aetna Maternity Program, Healthy Lifestyle Coaching and others
- Member rights and responsibilities
- How we make utilization management decisions, which are based on coverage and appropriateness of care, and include our policy against financial compensation for denials of coverage
- Medical Record Criteria, which is a detailed list of elements we require to be documented in a patient's medical record and is available in the **Office Manual for Health Care Professionals (PDF)**

How to reach us

Contact us by visiting our **Contact Aetna** page, calling the Provider Contact Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)** and selecting the "precertification" phone prompt, or calling patient management and precertification staff using the Member Services number on the member's ID card. The Medicare phone number is **1-800-624-0756, TTY: 711**. Our medical directors are available 24 hours a day for specific utilization management issues.

More information

Visit us online for information on how our quality management program can help you and your patients. We integrate quality management and metrics into all that we do, and we encourage you to take a look at the program goals.

Aetna Smart Compare™ designation program annual update

Updates include expansion to behavioral health and gastroenterology.

What is Aetna Smart Compare?

Aetna Smart Compare is a program designed to help members find high-quality, effective providers. We use an industry standard methodology to give members personalized recommendations that they can easily access through our secure member portals.

We will continue to publish designations for the following specialties for our commercial membership:

- Cardiology
- Endocrinology
- General surgery
- Medical oncology
- Pulmonology
- Primary Care Physicians (PCPs)
- Neurosurgery
- Obstetrics and Gynecology (OB/GYN)
- Orthopedics
- Vascular surgery

What are the updates?

We will start publishing designations for the following:

- Behavioral health — psychiatry
- Cardiothoracic surgery
- Gastroenterology
- Neurology
- Otolaryngology
- Plastic surgery
- Urology

Designation notification

Physician practices should receive notification by December 2024 regarding their designation. We exclude physicians who see few or no Aetna® members.

More information

Aetna Smart Compare is a national program. In California and Texas, we limit our commercial plans to self-insured members. Aetna Smart Compare designations have no bearing on a physician, physician practice or medical group's contract or on member benefits administered by Aetna.

Visit our **Aetna Smart Compare** page, where you can find guides for the designation measures. You can email **Aetna Smart Compare** if you have questions or want to provide feedback.

Costco Wholesale plans and PCPs

We will add a PCP name to member ID cards, but members can visit any PCP.

Starting January 1, 2025, Costco Wholesale plans will use the Aetna® PCP Choice feature. This means that Aetna will add the name of a local PCP to the member's ID card.

Costco plans *do not* require members to use the PCP listed on the ID card. We are implementing PCP Choice to encourage Costco employees and their family members to establish a relationship with a PCP to improve access to preventive and primary care.

The plan's PCP copay is the same regardless of whether the member visits the PCP listed on the ID card or any other network PCP.

Please don't turn members away if you are not listed as the PCP on the card. The plan will still pay.

If you have any questions, visit our **Contact Us** page. In the "Call us" column, choose "Aetna service centers" and dial the non-Medicare plans phone number.

The Aetna Premier Care Network Plus program is now multi-tiered

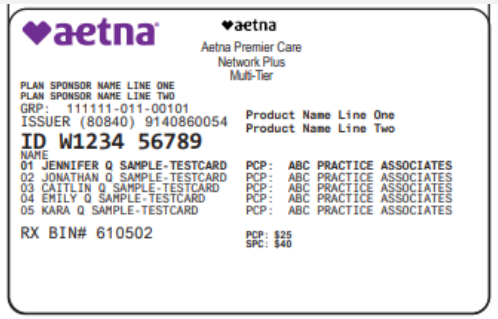
You may be an in-network provider in one of the two tiers. Please check for eligibility.

Starting January 1, 2025, some of your patients might be enrolled in our new Aetna Premier Care Network Plus Multi-Tier program. This program has two tiers:

- Tier 1: Maximum Savings
- Tier 2: Standard Savings

How to identify the card

The card is white or gold, and it will have "Aetna Premier Care Network Plus Multi-Tier" on it.



Check your participation status

You may be an in-network provider in one of the two tiers. Please check for eligibility. Don't assume that you are out of the network.

To check your participation and tier status, visit our **provider referral directory**. If a hospital or provider doesn't participate with us, it won't appear in the search results.

You can also find out whether you're participating or not by looking at the "limitations" section of a transaction:

Tier 1 participation

- Tier 1 hospitals and providers will see "maximum savings" in the system.
- This tier is the APCN Plus network. It's covered at the highest benefits level.

Tier 2 participation

- Tier 2 hospitals and providers will see "standard savings" in the system. But they could see both "maximum savings" and "standard savings" if both a hospital and doctors are included under the same tax ID. This is referred to as having a "mixed participation" status.
- This tier is our broad network of providers. It's covered at a reduced benefits level. Most doctors and hospitals not designated as Tier 1 but contracted with our broad network will be covered at the Tier 2 benefits level.

Out-of-network

- If a hospital or provider is out of the network, the system will display this: "We are unable to determine your participation status . . . Services rendered by providers that are not part of the patient's network are not covered."
- A member might still be covered for out-of-network benefits.

We're here to help

If you have any questions, visit our **Contact Us** page. In the "Call us" column, choose "Aetna service centers" and dial the non-Medicare plans phone number.

Now available: clinical questionnaire to request skilled nursing facility stays

Request stays on Availity and be prepared to complete the associated clinical questionnaire.

We're pleased to introduce our newest clinical questionnaire to request skilled nursing facility (SNF) inpatient stays for Medicare patients. As with our other clinical questionnaires, you can complete the SNF clinical questionnaire on our **provider portal on Availity**.*

How it works

A hospital or the SNF can request a stay. The process is easy, and you won't have to call us.

- Complete an electronic authorization request on Availity® if your patient needs to be transferred to a SNF.
- While completing an authorization request, Availity may invite you to complete a clinical questionnaire if your request pends for additional information.

Submitting a clinical questionnaire isn't required. We encourage you to complete it to reduce the time it takes to get a decision from us.

Once you complete the SNF clinical questionnaire and the authorization is approved, you're done. There's no need to call us. If the authorization pends, we'll request additional information for a medical necessity review.

Register for Availity

If you're not already registered for our provider portal on Availity, **visit the Availity website to register**. You can use the site at no cost. You can start submitting requests as soon as your account is ready.

Access our online resources if you need help

We created some resources to help you. Look for the following:

- Tips for completing the skilled nursing facility clinical questionnaire
- Frequently asked questions (FAQs) when completing the skilled nursing facility clinical questionnaire

You can find them on Availity, in the Resources section of Aetna's Payer Space. Refer to them to help guide you through the types of questions we may ask you and to get answers for questions from other providers like you.

You can submit discharge information on Availity, too

We'd like to remind you about our discharge date and disposition clinical questionnaire. On your patient's last covered bed day, we'll send a notification to your Availity Authorization/Referral dashboard. Click on the event and let us know whether the SNF has discharged your patient. If so, tell us when and where to.

See our list of all clinical questionnaires

Our SNF clinical questionnaire is one of several we have available. See the full list at **AetnaClinicalQuestionnaire.com**.

Clinical questionnaires are one of the tools we create to help make it easier for you to do business with us on your schedule, without having to call us.

*Availity is available only to providers in the U.S. and its territories.

Process claims faster by using certain fonts

Using all caps and Courier New can help your claims process quickly.

Did you know that using all caps and certain font styles can improve the processing speed and accuracy of your paper claims?

Data capture

As a part of our data capture process, we use Optical Character Recognition (OCR) programs. OCR is capable of reading text from documents sent as images. It breaks down the lines of text into individual characters. Many font types print characters close together, which means that OCR cannot adequately read them. Using all caps greatly improves character recognition.

How you can help

There are two things we are asking from our billing providers when submitting claims. These steps will both improve turnaround time and lower the risk of errors.

- Complete claims using all capital letters.
- Use a font that spaces every character the same regardless of how wide the character is. This type of font is known as a "monospaced" or "non-proportional" font. We recommend Courier New, which is available to everyone in their font settings, but any monospaced font will help.

You can now check commercial and Medicare appeals status on Availity®

Check the new display if you initiated your appeal on Availity.*

Last September, we rolled out an enhancement to the Availity appeals status indicator to include our decision on commercial and Medicare appeals.

Where you will find the decision indicator

You must select the Detail menu to view the updated status and decision, including decisions on an appeal that's already final. If new information is available, the decision will update.

Commercial appeals

For commercial appeals, the decision status will display as "Finalized" when the appeal is:

- Overturned
- Partially overturned
- Upheld
- Finalized

Note that you will continue to receive mailed appeals decision letters.

Medicare appeals

The decision status will continue to display as "Submitted" when the decision is Overturned or Partially Overturned. The decision status will display as "Finalized" when the appeal is:

- Upheld
- Voided
- Dismissed
- Withdrawn
- Resolved

Note that you will continue to receive mailed or faxed appeals decision letters.

Questions?

For more information, refer to the **Contact Aetna** page. Select the Providers tab. In the "Call us" column, choose "Aetna service programs" from the drop-down menu and use the "Medicare medical and dental plans" number or the "Non-Medicare plans" number.

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Tips for how to improve the patient experience and your own well-being

Research indicates that skilled, relationship-centered provider-patient communication is a key indicator of important health care outcomes.[1]

Communication quality and the strength of the provider-patient relationship can improve the patient experience, health outcomes, and adherence to therapy, and decrease medical errors, malpractice claims, and burnout.[2]

Practical solutions for provider excellence

We're here to support you. The following resources will help you stay informed and focus on what you do best: caring for your patients.

- **Aetna Patient Engagement Material Portal**
- **Availity** (Payer Space > Resources)*
- **Evoke360** (Resources > External/Training Resources)
- **Aetna.com** (Working with us > Patient care programs > CAHPS® survey)

These resources identify key topics and ways to discuss them with your patients, which can increase patient experience and health outcomes as defined by Consumer Assessment of Healthcare Provider Systems (CAHPS®) and the Health Outcomes Survey (HOS).

For additional support, please email **askSTARS@Aetna.com** or contact your dedicated Aetna® representative.

Simple steps, significant impact

As you go about your day, we encourage you to consider implementing some of these tips to enhance your patients' perception of care and overall experience:

- Consider investing in exam room stools — the act of sitting down with a patient increased their perception of time spent with them.[3]
- Allow the patient to speak freely without interruption. Studies show that patients are usually only allowed 11 seconds before being interrupted.[4]
- Close a visit by asking "Have we addressed the reason for your visit?" or "Is there anything else I can help you with today?" to allow a final opportunity for the patient to share concerns before you exit the room.

*Availity is available only to providers in the U.S. and its territories.

[1]Fuehrer S, Weil A, Osterberg LG, et al. **Building authentic connection in the patient-physician relationship**. Journal of Primary Care & Community Health. January 28, 2024; 15.

[2]Altamirano J, Kline M, Schwartz R, et al. **The effect of a relationship-centered communication program on patient experience and provider wellness**. Patient Education and Counseling. July 2022; 105 (7): 1988–1995.

[3]Golden BP, Tackett S, Kobayashi K, et al. **Sitting at the bedside: patient and internal medicine trainee perceptions**. Journal of General Internal Medicine. January 10, 2022; 37: 3038–3044.

[4]Phillips KA, Ospina NS, Montori VM. **Physicians interrupting patients**. Journal of General Internal Medicine. October 2019; 34 (10): 1965.

January 2025 provider manual updates

The updates apply to our commercial, Medicare and Student Health providers. The changes are not considered to be material edits. When we make material edits, we will tell you which sections of the manual have changed.

Still, we encourage you to read **the manual** once a year.

If you have any questions, get in touch with your Aetna® representative.

How to contact us about utilization management (UM) issues

Our staff members, including medical directors, are available 24 hours a day to answer your UM questions.

You can call us during and after business hours.

During business hours

Health care providers and staff may contact Aetna® during normal business hours (8 AM to 5 PM, Monday through Friday) by calling the toll-free precertification number on the member ID card. When only a Member Services number is on the card, you'll be directed to the Precertification Unit through a phone prompt or a Member Services representative.

After business hours

You can reach us in various ways.

- Visit our **Contact Aetna** page.
- If you have a question about a member covered by a commercial plan, call the Provider Contact Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)** and choose precertification.
- If you have a question about a member covered by a Medicare plan, call the Provider Contact Center at **1-800-624-0756 (TTY: 711)** and choose precertification.
- Call the patient management and precertification staff using the Member Services number on the member's ID card.

Atrial fibrillation and atrial flutter

Read on for tips about how to document and code.

Atrial fibrillation and atrial flutter are similar in that they are both heart rhythm disorders. The upper chambers of the heart are out of electrical sync with the lower chambers. Medications, surgery and other interventions can treat both conditions.

Documentation tips

Follow these guidelines:

- Specify whether the atrial fibrillation is paroxysmal, persistent permanent, or chronic.
- Do not use "history of" to describe a current active diagnosis of atrial fibrillation or atrial flutter, because according to coding guidelines, this means the condition no longer exists.
- Document if a pacemaker is in place for treatment and if the pacemaker is successfully managing the arrhythmia.
- If medications are needed to accompany the pacemaker, document this by linking the medication to the arrhythmia it is treating.

Document the treatment plan

Document the following:

- Medications — including beta-blockers, calcium-channel blockers, anti-arrhythmic medications and anti-coagulants
- Any diagnostic tests or procedures ordered or scheduled
- A smoking-cessation plan, if pertinent
- The date of the next follow-up appointment

Coding tips

If you are controlling atrial fibrillation or atrial flutter with medication, follow these guidelines:

- Assign code Z86.79 (personal history of other diseases of the circulatory system) only when there is no implant, no medications and no arrhythmia present.
- Assign code from category I48 (atrial fibrillation and flutter) if there is a pacemaker in place even if no arrhythmia is noted in the documentation for current date of service.
- Assign code Z79.01 if documentation supports the long-term use of an anti-coagulation drug.

Be sure to verify whether Aetna® members are eligible for care before turning them away

Don't turn away Aetna Passport to Healthcare members who show as ineligible after conducting a 270/271 EDI transaction. Aetna Passport to Healthcare accesses Open Choice® PPO.

Aetna Passport to Healthcare members are appearing ineligible for care even though they are eligible. Passport to Healthcare group numbers normally start with 8639 or 1493.

Due to how our eligibility checks are run, when you do an eligibility check on Aetna Passport to Healthcare members, the system will not display eligibility or benefits information. Instead, it will give you a phone number to call.

What you should do

We ask that you please call the number you see (you might have to expand fields or scroll to find the number) instead of turning the member away.

If you can't find the number, please call the number on the back of the member's ID card.

What you should not do

Please do not tell members that Aetna doesn't cover them. You must call the phone number to obtain eligibility and benefits information.

A note about the Epic system

If you are using the Epic system for your 270/271 transactions and it shows that the patient has been rejected or is not active, Epic asks that you please submit a ticket to your technical team (if you have one) and ask them to "install the Epic fix SLG 8861771."

If you cannot have the Epic fix installed, you will need to call the number on the member's ID card to confirm eligibility and benefits.

More information

We are working to correct this problem and will be in touch when we have more details.

Tests available for cold and flu season

Use combination testing for a faster diagnosis.

This flu season, combination testing from our Nationally Preferred Lab Network (Quest Diagnostics®, Labcorp and BioReference) is a convenient way to test patients for SARS-CoV-2 (COVID-19), influenza, RSV and other respiratory infections.

Convenient and efficient testing that supports a faster diagnosis, the SARS-CoV-2 (COVID-19) and respiratory molecular combination tests use a single specimen to test for common respiratory pathogens, providing timely results when you need to identify what is causing your patient's illness.

The combination test:

- Distinguishes between SARS-CoV-2 (COVID-19), influenza A and B, RSV, and other respiratory pathogens with just one swab
- Eliminates the need for multiple tests or patient visits, which can result in a 24- to 48-hour turnaround time
- Helps you determine the appropriate care path for your patients, improving overall outcomes

We are all committed to helping health care providers confirm a diagnosis quickly and confidently for better patient care.

Behavioral health

Stay informed about behavioral health coverage updates so you can deliver the best possible treatment to your patients.

Updated medical record documentation standards

You can find treatment documentation standards in our provider manual.

Remember that our treatment documentation standards apply to behavioral health providers

We want to ensure that member care is appropriately documented. We also must comply with state treatment documentation regulations. Therefore, we maintain specific standards regarding treatment documentation. In some cases, we are required to audit treatment records.

It is important that you understand and apply these standards.

We've updated our medical record documentation standards

For detailed information, please see the new **Office Manual for Health Care Professionals**, which includes information for behavioral health providers. You can find information related to our documentation standards in the Behavioral Health Quality program section. Appendix A lists the specific criteria we use when auditing treatment records.

Thank you for your efforts to maintain detailed, comprehensive and organized treatment records.

Refer patients to Vita Health for youth suicide risk reduction

The Vita Health treatment model combines teletherapy and psychiatry.

In 2022, according to the Centers for Disease Control and Prevention (CDC), suicide was a leading cause of death for young people from age 10 to 14 and the third leading cause of death from age 15 to 24.[1] Furthermore, parents and caregivers report **higher levels of stress**.[2]

Families need access to specialized care, and we are committed to reducing member suicide attempts by enhancing our network with providers who specialize in risk-reducing suicide care protocols and interventions.

Vita Health

Vita Health delivers behavioral health services that specialize in suicide risk reduction. This unique virtual treatment model combines teletherapy and psychiatry so that teens and young adults can receive services from the comfort of home. The typical length of individual treatment is 12 weeks (about 3 months), and patients can get this treatment while seeing their own behavioral health provider if necessary.

Vita Health provides the only clinically validated solution for suicide risk reduction using tools and techniques designed to provide individuals with the necessary skills to help them manage crisis behavior. Vita Health, an evidence-based proven approach to suicide risk reduction, has been shown to prevent suicide attempts by over 25% and reduce deaths by 80%.[3,4]

How to make a referral

Visit **Vita Health** or call **1-844-866-8336**.

More information

Vita Health services are currently available in 43 states. Check member plan eligibility for coverage areas. Ask about copay waivers; plan exceptions may apply.

[1]CDC, WISQARS. **Leading causes of death**. 2021. Accessed on September 18, 2024.

[2]U.S. Department of Health and Human Services. **U.S. Surgeon General issues advisory on the mental health and well-being of parents**. Press release, HHS Press Office, August 28, 2024.

[3]Bernecker SL, Zuromski KL, Curry JC, et al. **Economic evaluation of brief cognitive behavioral therapy versus treatment as usual for suicidal U.S. Army soldiers**. JAMA Psychiatry. March 1, 2020; 77 (3): 256–264.

[4]King CA, Arango A, Kramer A, et al. **Association of the youth-nominated support team intervention for suicidal adolescents with 11- to 14-year mortality outcomes: secondary analysis of a randomized clinical trial**. JAMA Psychiatry. May 2019; 76 (5): 492–498.

Visit a new CVS Health® culturally relevant site to further your understanding of depression

Discover educational materials, depression screenings and resources.

When a patient screens positive for depression, do you follow up by offering resources, prescribing medication or referring them to a mental health professional?

A culturally relevant mental well-being website

At CVS Health, we are dedicated to expanding access to depression screenings with intentional follow-up care. The Mental Well-being Health Equity Team has developed and launched the first culturally relevant mental well-being website that is accessible to everyone — providers, community members and Aetna® subscribers alike. The **CVS Health Be Seen, Be Heard** site provides cultural insight, educational materials, access to depression screenings and resources to help locate and fund mental health treatment.

Can you spot depression? Test your knowledge.

Depression is a debilitating condition that can worsen physical symptoms and disrupt treatment plans when patients are unable to fully engage in their care. Globally, depression contributes to significant morbidity and mortality, straining interpersonal relationships and

increasing the risk of substance use disorder, lost workdays, suicide and adverse medical outcomes. Are you prepared to recognize depression in your patients? Test your knowledge with a **Medscape five-question quiz**.

Get involved

Sharing knowledge is not just about exchanging information. It's about fostering a genuine desire to help others grow and develop new capabilities. When we share knowledge, we create learning opportunities and strengthen communities. We encourage you to share this new culturally relevant website with colleagues, patients, friends and family.

We value your responses to our annual practitioner surveys

Your increased participation in the 2025 survey will help us help you (and our members).

We know that it's important to include you in our quality programs because you are the ones who improve member outcomes.

About our surveys

Our yearly surveys help us:

- Monitor your experience with Aetna®
- Make you aware of our programs and services
- Learn about our members' access to services

We review survey results as well as data from complaints, appeals and out-of-network claims to better understand what's happening within our practitioner network and our membership. We use this information to improve our services and clinical quality.

Thank you for responding to the 2024 survey

We received responses from 15.56% of the practitioners who received a survey. This was more than a 50% increase from 2023. We saw a similar increase for state-specific surveys.

Your increased participation gave us better results. Based on them, we will be working to improve our communications related to specific requirements, such as appointment wait times and documentation standards.

Not receiving the surveys?

The surveys are sent via email to random practitioners. Please **update your contact information** so that we're sure to get feedback from as many of you as possible over time.

Sharing information can lead to better care

Coordinating care among all providers helps patients get what they need.

Sharing information helps patients get better care and eases their transitions between health care settings. It ensures that providers can use the patient's medical history to guide treatment. As a result, the quality of care, safety and effectiveness of provider recommendations can improve.

Care coordination between behavioral health (BH) and medical providers improves patient care

Care coordination improves patient interactions with the health care system in these ways:

- It eliminates disjointed care by creating the feeling that patients are working with a team focused on their care.
- It provides referral clarity by helping patients schedule appointments and telling them what to expect from a referral.
- It improves care with primary care and BH providers by sharing relevant diagnosis and treatment information to allow for adjustments to treatment plans.
- It prevents information loss by making direct connections between providers to reduce administrative errors or lost information.

HIPAA guidelines (PDF) related to sharing BH information

- Physicians may disclose Protected Health Information (PHI) (whether orally, on paper, by fax or electronically) for treatment, payment and health care operations without consent or authorization.
- HIPAA treats mental health information the same as other information.
- Health care providers may share any PHI contained in the medical record for treatment, case management, and coordination of care. Examples of mental health information in the medical record and subject to the same HIPAA standards as other PHI include:
    - Medication prescription and monitoring
    - Counseling session start and stop times
    - The modalities and frequencies of treatment offered
    - Results of clinical tests
    - Summaries of diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date

Exception: Covered entities must obtain individuals' authorization to disclose separately maintained psychotherapy session notes.

You can help improve patient care coordination

Request that patients sign release of information forms for all providers involved in their care. This will help ensure prompt communication between providers when it is necessary.

Care coordination is reimbursable

The CPT® codes* for collaboration include: 99484, 99492, 99493 and 99494.

Get Medicare-related information, reminders and guidelines.

Clinical Laboratory Improvement Amendments (CLIA) requirements

Always submit Medicare professional claims with the appropriate CLIA numbers.

Beginning January 1, 2025, we will deny any Medicare professional claim that does not contain a CLIA number. The Centers for Medicare & Medicaid Services (CMS) requires this number.

Claim submission process

CLIA numbers must be submitted on all Medicare professional format claims for clinical laboratory tests, in accordance with Medicare requirements.

If you don't submit the required CLIA numbers, you will not be reimbursed. We will deny your claims, and you will have to resubmit them with valid numbers.

Please remember to be diligent with your claims to avoid payment issue and to comply with CMS.

Your required annual Medicare compliance training and attestation was due on October 31, 2024

If you missed the deadline, complete your attestation by December 31, 2024.

We require participating providers in our Medicare Advantage (MA) networks to meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related entities (FDR) and attest annually.

2024 direct provider notification

In June, we sent MA participating providers a training and attestation notice to the compliance email address(es) identified in your 2023 attestation. If we did not have your email address or if the email bounced, we sent a postcard in August reminding you to complete your training(s) by October 31, 2024.

Complete your training and attestation by December 31, 2024

Visit our **Medicare resources** page and review the FDR Medicare compliance guide, the SNP Model of Care (MOC) trainings (if applicable), the frequently asked questions document and other resources provided. Then complete your attestation for your contracted plan(s).

Attestations that are downloaded and manually signed, and then emailed or faxed, will not be credited.

Where to get more information and assistance

Email us at **FDRAttestation@Aetna.com**.

Aetna Individual Medicare Advantage (MA) 2025 plan expansion

You might be a participating provider for the new counties.

We're expanding our Individual MA plans to 76 new counties for 2025. Depending on your contract, you may be listed as a participating provider in our MA networks.

What are the new counties?

On **Aetna.com**, you can view our **2025 MA Individual expansion counties (PDF)**.

2025 Annual Enrollment Period (AEP)

The Medicare AEP is from October 15, 2024, through December 7, 2024. We believe that Medicare beneficiaries will be interested in our plans because of our healthy Star Ratings. For 2025, our overall enrollment-weighted rating is 4.27 out of 5 stars (measurement period FY 2023 and early 2024). These ratings reflect the care you give to your patients.

More about our MA products

- View our **Aetna Medicare Advantage plans quick reference guide (PDF)**.
- View the **At a Glance reference guide (PDF)**.
- Find out how to **verify your patients' eligibility**.

How to get contracted for MA plans

If you're not currently contracted for our MA plans, please visit our **Aetna Health Care Professionals page**. Scroll down to the "Help to make your job easier section" and choose "Join our network." You can then complete the form online.

Medicare annual enrollment is open until December 7

Patients who saw changes to their Individual Medicare Advantage (MA) plan can choose a new one.

Each year, we assess our ability to meet the health care needs of our members and adjust our plans to ensure they can deliver an excellent member experience.

What changed

For 2025, we discontinued Individual MA plans or specific plans in certain counties. We notified affected members before October 2 and told them that they can choose from other Aetna® plans.

Enrollment

Affected members can enroll in a new plan during the annual enrollment period, which started on October 15 and ends on December 7. There is also a special enrollment period from December 8 to 31. If members enroll between October 15 and December 31, they will have a new plan effective January 1, 2025.

If they do not enroll in a new MA plan by December 31, they will default back to Original Medicare and will not have drug coverage unless they enrolled in a standalone Part D plan.

More information

If your patients have questions, they can get in touch with their licensed Medicare agent or call Aetna Medicare Telesales at **1-833-243-9522 (TTY: 711)**. To get help with choosing a new plan, they can visit our **Aetna Medicare Plans** page.

What to do if you receive a Quality Improvement Organization (QIO) notification of appeal

Complete a Fax Back Form (FBF) to the Aetna Fast Track Appeals Team.

The Centers for Medicare & Medicaid Services (CMS) requires that all Medicare Advantage (MA) members be given the right to request an expedited review upon receiving a discontinuation or denial of previously approved services in a skilled facility, Home Health Agency (HHA), Comprehensive Outpatient Rehabilitation Facility (CORF) or hospital.

This expedited review is also referred to as a Fast Track Appeal.

If you receive a QIO notification of appeal, read the following:

- If you are a skilled facility, HHA or CORF, you must hand deliver a Detailed Explanation of Non-coverage (DENC) to the member as soon as possible but not later than noon of the day after the QIO notification.
- If you are a hospital and a member is appealing a discharge from an inpatient stay, you must hand deliver a Detailed Notice of Discharge (DND) to the member no later than noon of the day after the QIO notification.
- In accordance with CMS requirements, the MA plan must document the date you give the DENC (or DND) to the member. Put this date on a completed Fax Back Form (FBF) and fax it to the Aetna Fast Track Appeals Team at **1-860-754-2579**. The Plan will make three diligent attempts to get a completed FBF from you.

See the **appeals guidance update (PDF)** (section 100.2.1, page 110) for more information.

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